Northern Inyo Hospital

July 15 2020 Regular Meeting

July 15 2020 Regular Meeting - July 15 2020 Regular Meetin

AGENDA

NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS REGULAR MEETING
July 15, 2020 at 5:30 p.m.
2957 Birch Street, Bishop, CA

Northern Inyo Healthcare District invites you to attend this Zoom meeting:

TO CONNECT VIA **ZOOM**: (*A link is also available on the NIHD Website*)
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

PHONE CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: At this time, persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the agenda.
3. New Business:
   A. Network Security Penetration test results (*information item*).
   B. District Board Resolution 20-05, Cares Act Funding (*action item*).
   C. Policy and Procedure approval, *Pension Funding Policy* (*action item*).
   D. Amendment 5 to the NIHD Defined Benefit Retirement Plan (*action item*).
   E. Approval of annual Appropriations Limit, District Board Resolution 20-06 (*action item*).
   F. District Board Resolution 20-07, Re-funding of 2010 Revenue Bonds (*action item*).
   G. Presentation on Managing NIHD Investment Portfolio (*information item*).
   H. Policy and Procedure approval, *Pathways for Development, Review, and Revision of Nursing Standards* (*action item*).
4. Reports:
   A. Pioneer Home Health quarterly report (*information item*).

B. Building separation construction project update (*information item*).

C. ROI Committee update approval (*action item*).

D. Physician recruitment update (*information item*).

5. Chief of Staff report, Stacey Brown MD:

A. Annual Approvals (*action items*):

1. *Standardized Procedure – Certified Nurse Midwife*
2. *Standardized Procedure – General Policy for the Nurse Practitioner or Certified Nurse Midwife*
3. *Utilization Review Plan (2020)*

Consent Agenda (action items)

6. Approval of minutes of the June 17 2020 regular meeting
7. Approval of minutes of the June 24 2020 special meeting
8. Approval of minutes of the June 26 2020 special meeting
9. Approval of minutes of the June 27 2020 special meeting
10. Approval of minutes of the July 6 2020 special meeting
11. Interim Chief Executive Officer report
12. Chief Nursing Officer report
13. Interim Chief Medical Officer report
14. Policy and Procedure annual approvals

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15. Reports from Board members (*information items*).
16. Adjournment to Closed Session to/for:

A. Conference with Legal Counsel, anticipated litigation, significant exposure to litigation (*pursuant to Government code Section 54956.9(d)(2*)) 2 cases.

B. Public Employee Performance Evaluation (*pursuant to Government Code Section 54957(b*)) title: Interim Chief Executive Officer.

17. Return to Open Session and report of any action taken (*information item*).
18. Adjournment.

In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.

NORTHERN INYO HEALTHCARE DISTRICT
PRESENTATION TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: 7/6/2020

Title: **SECURITY PENETRATION TEST RESULTS OVERVIEW**

Presenter(s): Bryan Harper

Synopsis: Cyber-attacks are an everyday occurrence for companies across all industries. Stern Security performed the following penetration test on Northern Inyo Healthcare in of May 2020. The purpose of the penetration test was to determine the security posture of the organization and discover potential vulnerabilities. Through the penetration test, Stern Security's data security team emulated real world attacks to test the organization's defenses and make staff aware of vulnerabilities before adversaries find them

Prepared by: Bryan Harper / Acting ITS Director & DSO
Name
Title

Reviewed by: _____
Name
Title

Approved by: Kelli Davis
Name
Title INTERIM CEO

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

2020 Penetration Test

Executive Report

Northern Inyo Healthcare

Assigned Stern Security Team:
Jon Sternstein, CISSP #378687
Peter Nelson

Report Date: 5/27/20

Engagement #P20020601

Information contained in this report is considered confidential

Table of Contents

About Stern Security

Stern Security is a cyber security company headquartered in Raleigh, NC. Our team firmly believes in developing long lasting relationships with organizations instead of the "hit and run" approach used by many companies today. At Stern Security, we speak clearly to the business professionals and non-tech individuals within organizations and save our "tech speak" for the technical teams.

The team at Stern Security is formed of highly trained cyber security professionals with many years of experience from security roles in numerous industries. Our team members have major data security certifications, have won security awards and security competitions, taught security classes and have spoken at security conferences. We only assign senior security professionals to perform client work.

EXECUTIVE SUMMARY

Cyber-attacks are an everyday occurrence for companies across all industries. Stern Security performed the following penetration test on Northern Inyo Healthcare in of May 2020. The purpose of the penetration test was to determine the security posture of the organization and discover potential vulnerabilities. Through the penetration test, Stern Security's data security team emulated real world attacks to test the organization's defenses and make staff aware of vulnerabilities before adversaries find them.

There are some great security measures in place at Northern Inyo Healthcare. Stern Security was impressed with the creative security measures in place at NIH. Solutions such as admin account usage alerts, decoy systems, and Security Information Event Management (SIEM) systems, are more common in much larger organizations with full security teams. Great work! Some of the positive security measures include:

1. Proactive Penetration Test
2. Security Awareness Training
3. Limited External Network Attack Surface
4. Web Filtering
5. Alerting on Admin Account Usage
6. Decoy Web Server Alerts
7. Security Information Event Management (SIEM) System

While there are great security measures in place, security can always be improved, and Stern Security was able to discover vulnerabilities.

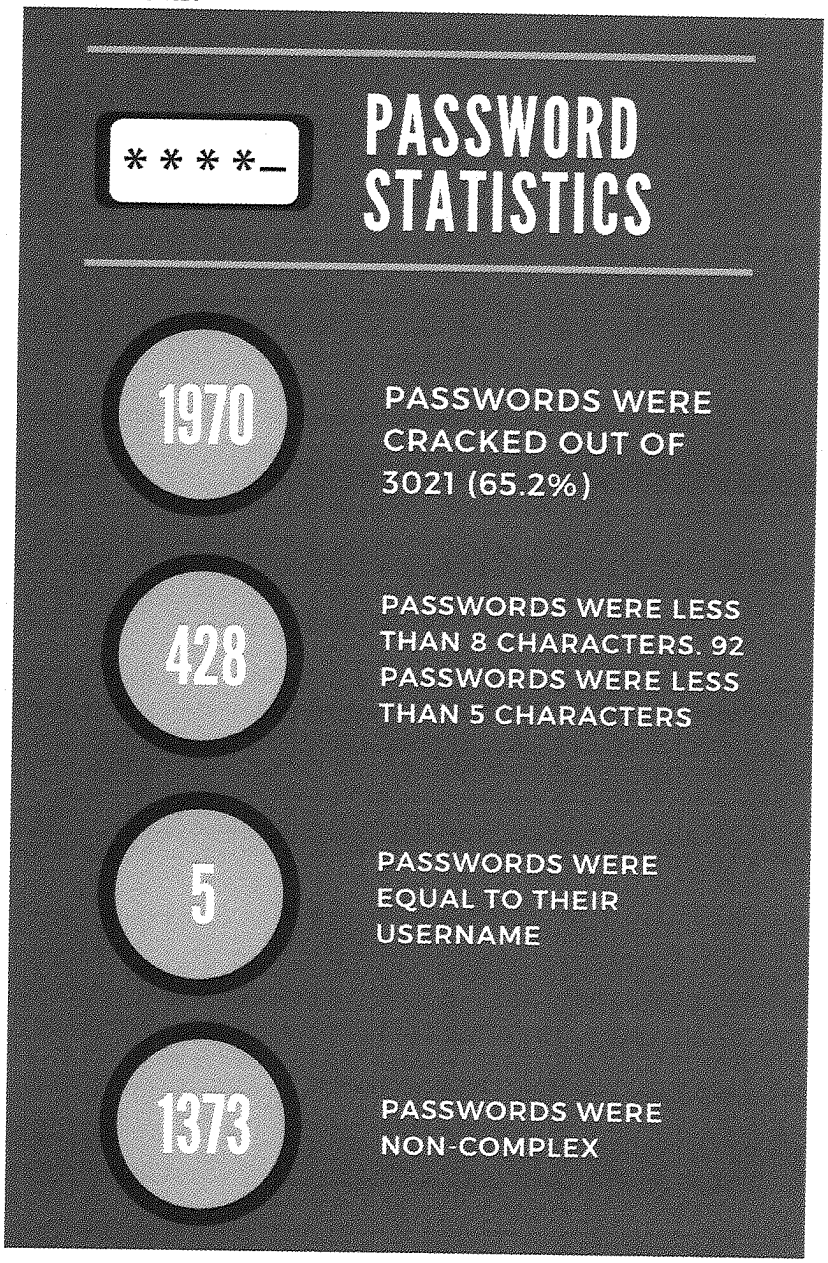
The top vulnerabilities include:

1. No 2-factor Authentication
2. Weak Passwords
3. Insecure Storage of Sensitive Information
4. Outdated Systems

Overall, Northern Inyo Healthcare has good security measures in place and has made significant strides to improve the security posture. Several vulnerabilities that Stern Security discovered pose a high risk to the organization and their remediation efforts should be prioritized. Stern Security has several recommendations to increase the security posture of the organization. Further strengthening the password policy, implementing 2-factor authentication, and updating systems will go a long way to increasing the security posture of the organization.

Password Statistics

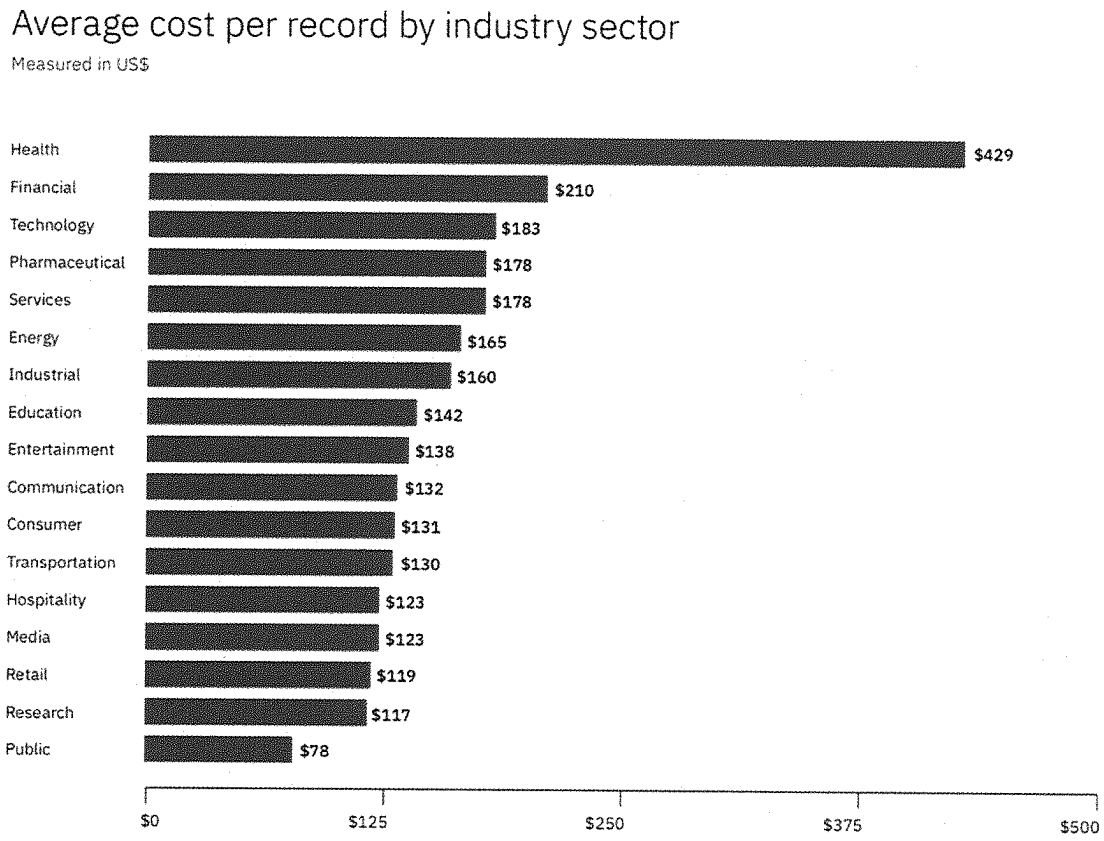
As passwords were one of the top issues, Stern Security performed a deeper dive into the passwords utilized across the organization. Note – the password statistics include both active and inactive accounts.



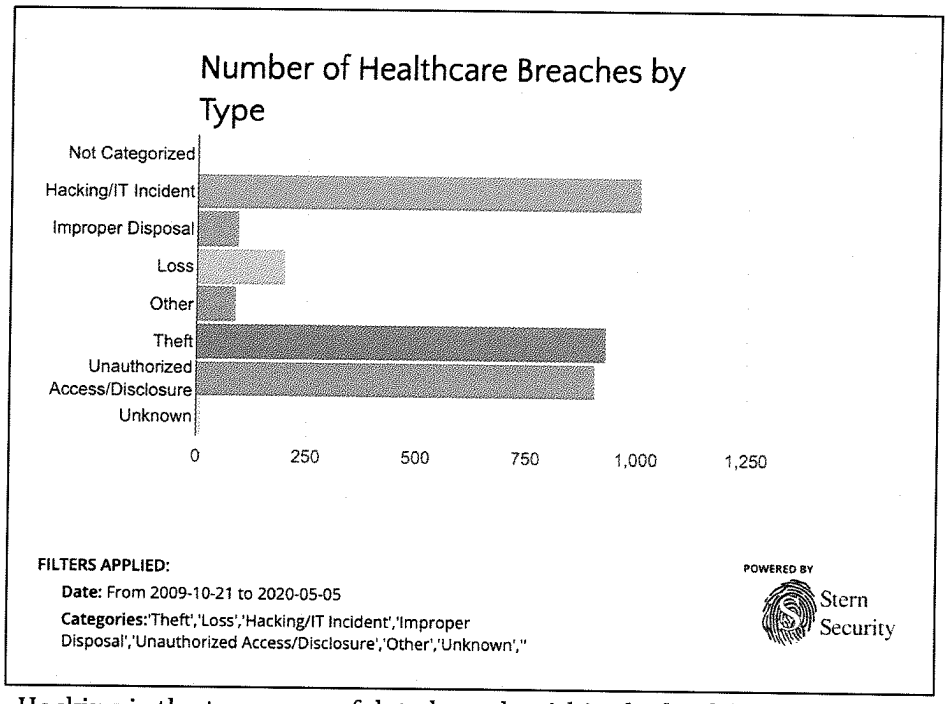
Risk

Performing a penetration test was imperative to determine the security posture of the Northern Inyo Healthcare, view the environment from the eyes of an attacker, give recommendations to the organization on how to increase their security, and help the Northern Inyo Healthcare protect its data. Penetration testing is becoming increasingly critical, as all sensitive data is available in electronic format.

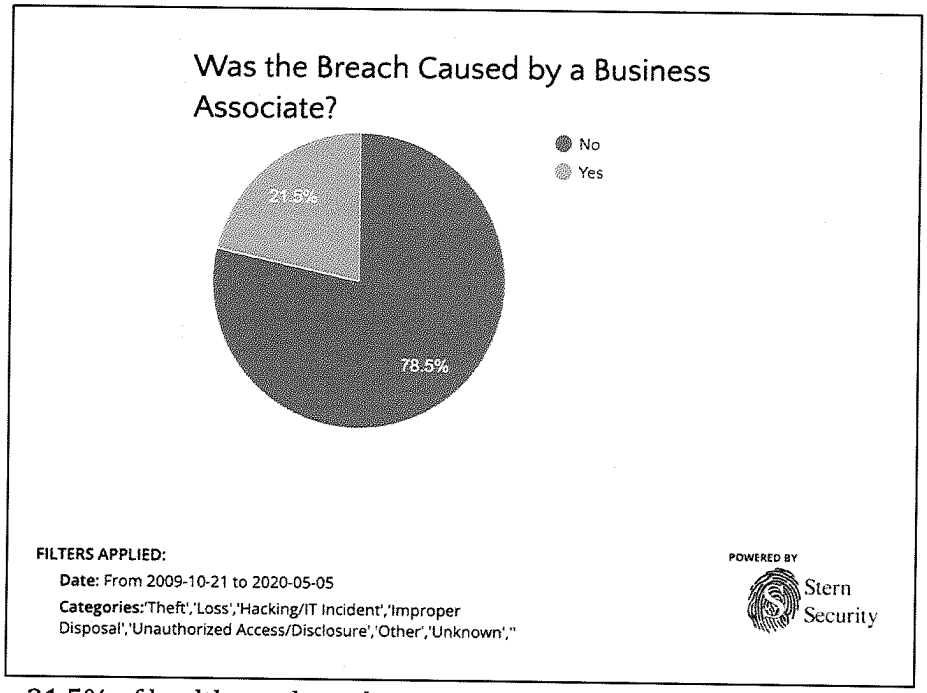
According to the 2019 Ponemon Institute benchmark study, the average cost of a data breach was $429 per compromised account across in the healthcare industry.



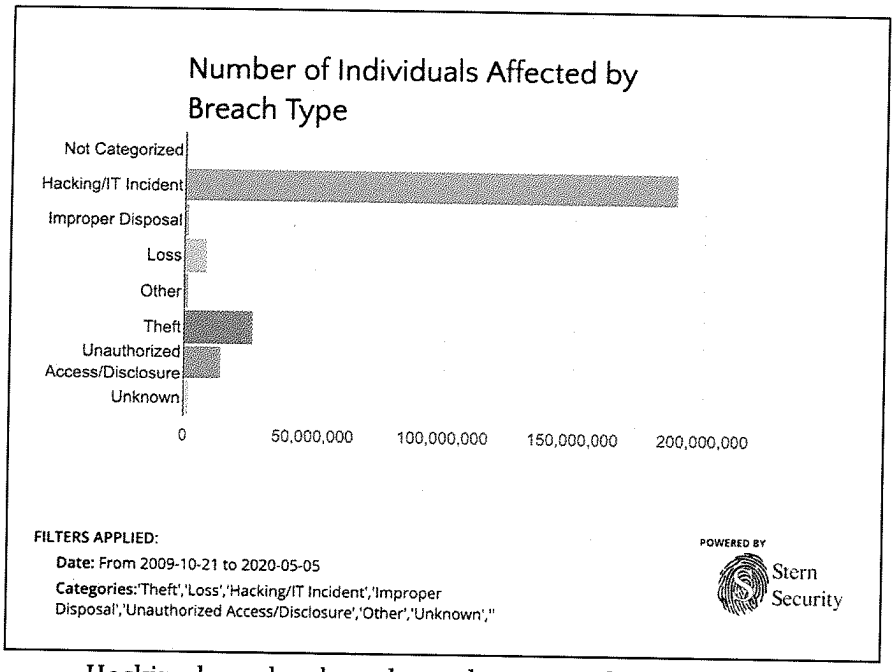
Cost of a Data Breach by country (Ponemon Institute, 2019)



Hacking is the top cause of data breach within the healthcare industry



21.5% of healthcare breaches were caused by a Business Associate



Hacking breaches have been the cause of most PHI loss

To measure the risk, Stern Security gives each discovered vulnerability a rating based on the NIST (National Institute of Standards and Technology) Information Security Guide for Conducting Risk Assessments. The risk is a variation of high, medium, or low rating based on a calculation of the likelihood of a threat event occurrence compounded by the impact of a threat.

TABLE I-2: ASSESSMENT SCALE – LEVEL OF RISK (COMBINATION OF LIKELIHOOD AND IMPACT)

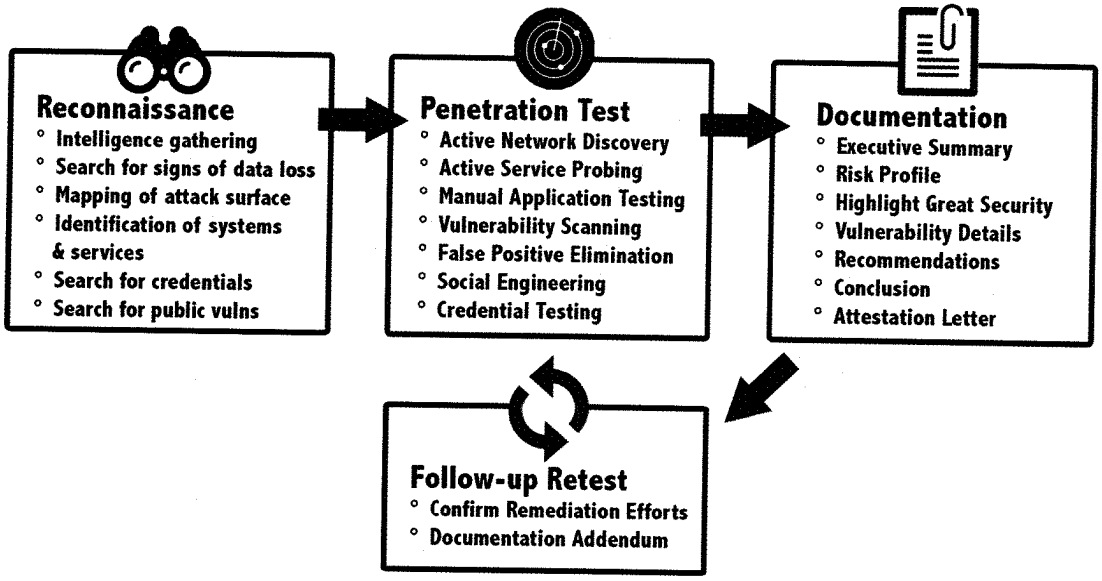
Likelihood (Threat Event Occurs and Results in Adverse Impact)	Level of Impact				
	Very Low	Low	Moderate	High	Very High
Very High	Very Low	Low	Moderate	High	Very High
High	Very Low	Low	Moderate	High	Very High
Moderate	Very Low	Low	Moderate	Moderate	High
Low	Very Low	Low	Low	Low	Moderate
Very Low	Very Low	Very Low	Very Low	Low	Low

Risk Scale – Overall Risk (NIST, 2012)

Methodology

Stern Security's methodology follows internally developed data security tactics as well as public penetration testing standards including the Open Web Application Security Project (OWASP) and the Penetration Testing Execution Standard.

The penetration test was divided in to several sections, Reconnaissance, External Penetration Testing, Internal Penetration Testing, Working with Staff, and Reporting.



Reconnaissance

The first phase of the Penetration Test was the reconnaissance phase. The Reconnaissance phase began on May 6th, 2020. During this stage, Stern Security utilized passive tests to discover information about the client environment. These tests included searching the underground web for information about the organization, reviewing public breaches, social networking sites, and search engines. The results of this examination allowed Stern Security to map the environment with information freely available on the Internet and gave the security team the intelligence they needed to target certain vulnerabilities.

External Penetration Test

The External Penetration Testing phase began on May 6th, 2020 and continued through the end of the engagement. This phase utilized the information discovered within the Reconnaissance phase to actively assess the organization's external hosts in order to access

the internal network. In this stage, Stern Security targeted the organization similar to how an external attacker would. The Penetration Testing team manually assessed the external websites, VPN portals, and other available external services. Stern Security also performed the vulnerability scans during this phase. This is usually the stage where social engineering attacks a performed, but this was not in scope of this particular engagement.

Internal Penetration Test

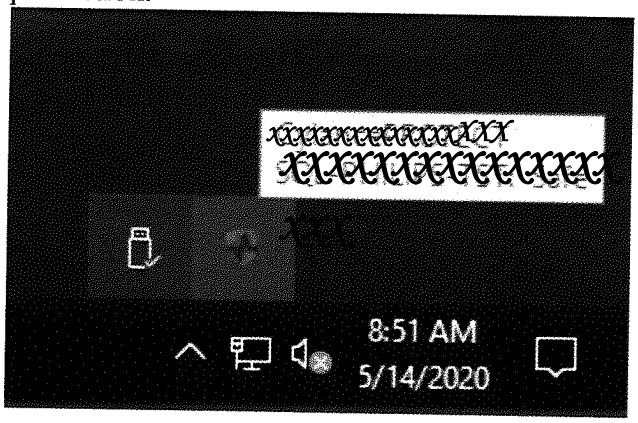
The Internal Penetration Testing phase began on May 11th, 2020. Stern Security delivered a laptop that was plugged into the internal network. Stern Security performed security tests from the internal network. This showed the organization's exposure from the viewpoint of an attacker or malware that has infiltrated the internal network or compromised an internal system. The security team was given a list of VLANs and hosts to avoid. Stern Security was not given any usernames and passwords so the penetration testers had to find a way gain access to systems.

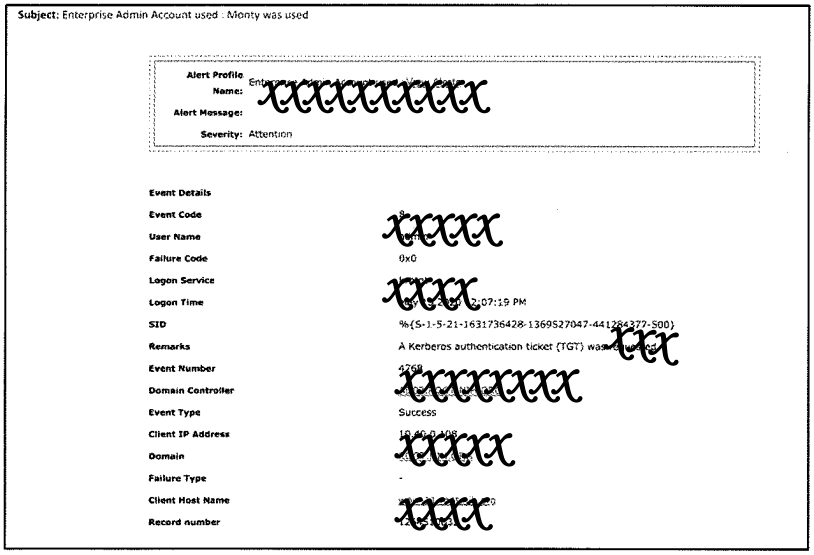
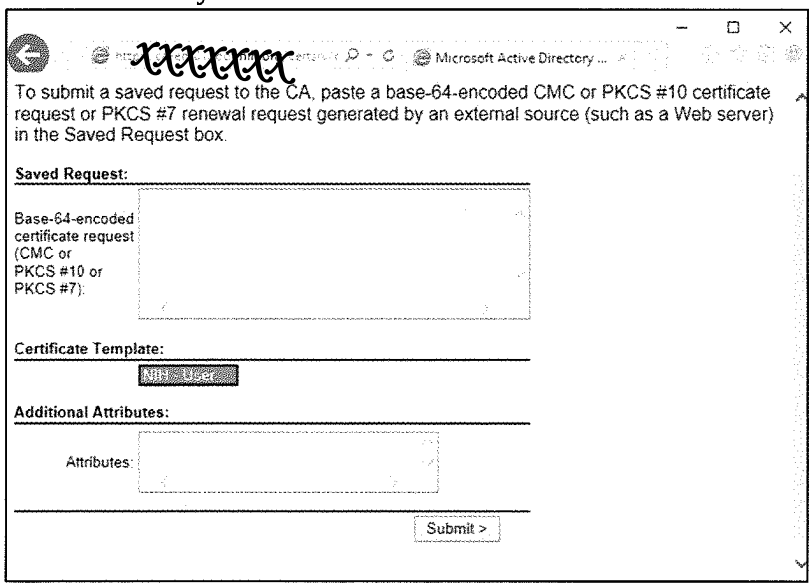
Reporting

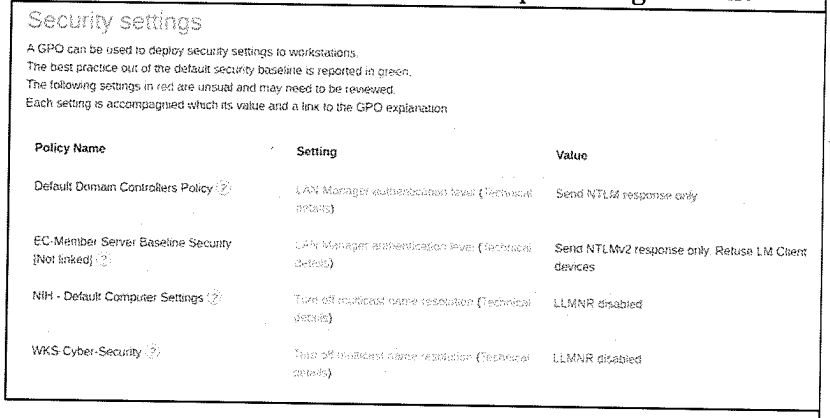
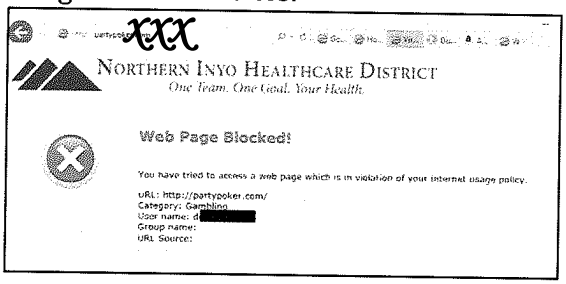
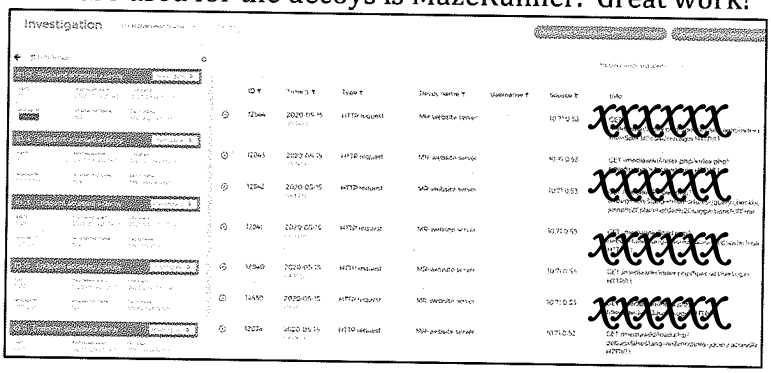
The final phase of the penetration test was the Reporting phase. This is where all of the data was combined, recommendations were listed, and this report was delivered to Northern Inyo Healthcare.

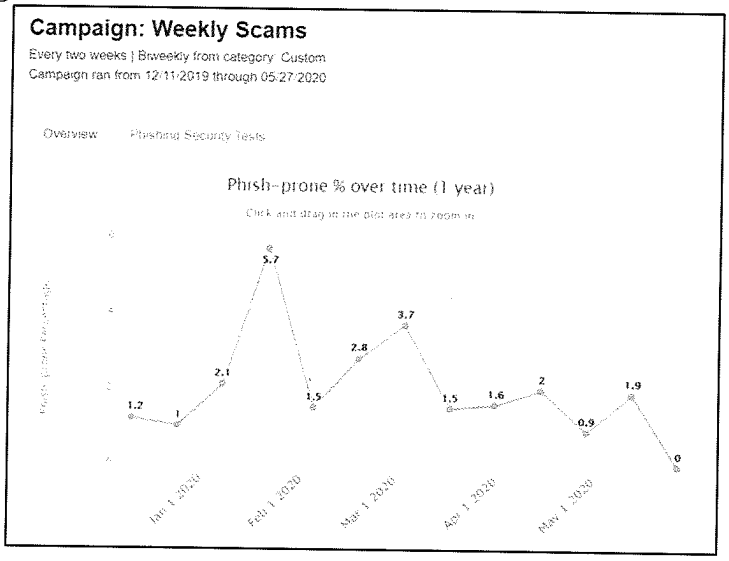
POSITIVE SECURITY MEASURES

It is important to note some great security measures that are in place at Northern Inyo Healthcare. For an organization of its size, NIH has some great protective measures in place, some of which are more common in much larger organizations.

ID	Security Measure	Details
1	**Proactive Penetration Test**	Northern Inyo Healthcare hired Stern Security to perform this very penetration test. This was a great proactive security measure by Northern Inyo Healthcare to increase their security posture!
2	**Limited External Hosts**	Very few servers are accessible from the public internet. Only nine hosts were accessible externally (for the in-scoped devices) and these servers only had a minimum amount of services available.
3	**DNS Zone Transfer not Allowed**	"DNS Zone Transfers" are not allowed on the DNS servers.
4	**Security Information Event Management (SIEM) System**	The organization has a SIEM in place to collect, correlate, and analyze logs from various sources. The system is hosted at alienvault.root.nih.org (10.20.0.26).
5	**Cylance Endpoint Protection**	The organization utilizes Cylance for next-gen endpoint protection. 
6	**Password Rotation**	In discussions with the NIH Team, the password policy has been increased from zero password rotation to a password rotation. Some accounts were never changed and now they have new passwords. Great work!
7	**No open shares**	No open shares were found in the VLANs that were scanned. Open Shares are shared folders that are accessible to anyone without credentials.

8	**Alert tripped when the domain admin account is used**	An email alert is sent when the 'admin' account on the domain is used. "AD Audit" is the tool used to trip this alarm.  Alert tripped on May 13,2020 12:07:19 PM
9	**Users can only Issue "User Certificates"**	The certificate templates are limited to "user certificates" for end users. They cannot issue web server certificates. 
10	**Vulnerability Scans**	NIH performs vulnerability scans with OpenVAS.

11	**LLMNR and NetBIOS-NS Disabled**	The organization has disabled LLMNR and NetBIOS-NS protocols to limit certain local network poisoning attacks. 
12	**Web Filtering**	The organization performs web filtering to block certain categories of websites. 
13	**Decoy Web Server Alerts**	NIH has deployed decoy web servers which trip alerts when anyone browses to the site. This is a neat way to find systems that are scanning the network for vulnerable devices. The software used for the decoys is MazeRunner. Great work! 
14	**Current Wireless Encryption Standards**	All of the wireless networks in scope utilized a form a WPA2 encryption. No outdated WEP wireless networks were discovered.

15	**Security Awareness Training**	NIH performs both ongoing and annual security awareness training for staff. The organization utilizes KnowBe4 for regular phishing exercises and comprehensive annual testing. NIH tracks progress for staff and the organization over time. This staff education greatly helps the security posture of the organization. Excellent work! 

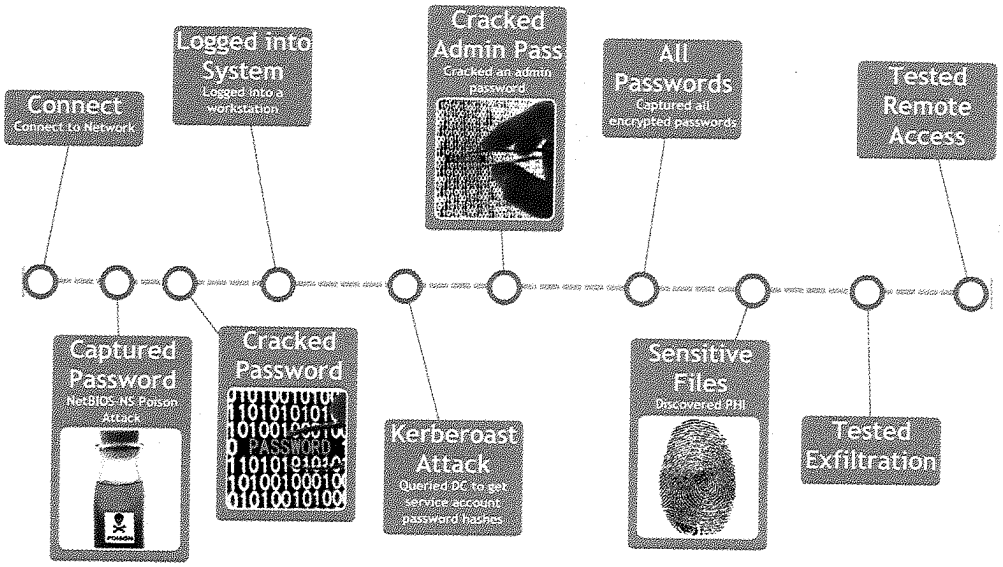
Interesting Findings

ID	Finding	Details
1	**Honeypot**	NIH has deployed a honeypot device on the external network. Honeypots are falsely vulnerable devices that distract attackers and allow a security team to block potential intruders and analyze attacks. Stern Security discovered the honeypot during the external penetration test.

Internal Penetration Test Attack Timeline

During the internal portion of the penetration test, Stern Security deployed a laptop on site which was plugged into the internal network. Stern Security was not given any network credentials. Instead, the purpose of this portion of the test was to assess the security posture from inside of the network from the prospective of an uncredentialled intruder. This would determine how much data an attacker that gained access to the internal network would be able to compromise.

During the week, Stern Security was able to successfully gain access to all usernames and encrypted passwords, and thousands of sensitive files on the network.



Timeline of the Internal Penetration Test

DISCOVERED VULNERABILITIES

External Vulnerability Summary

ID	Vulnerability	Risk Level	Resolution
E1-20	**No 2-factor Authentication on External Portals**	HIGH	Enable 2-factor authentication on [redacted], and any other external portal.
E2-20	**Outdated Encryption Protocols in use - SSLv3 & TLSv1**	LOW	Disable SSLv2 and SSLv3 on the servers and only allow TLS 1.2 or higher.

Internal Vulnerability Summary

ID	Vulnerability	Risk Level	Resolution
I1-20	**Weak Password Policy**	HIGH	Utilize a minimum password length of 8 characters, complexity, and a password lock out. Administrative (server and workstation) and Service accounts should have a policy of at least 20-character passwords/passphrases with complexity. Sign up for domain alerts on haveibeenpwned.com to be notified if any NIH accounts appear in known breaches. Instruct individuals to change their password if their account appears in a public breach. Ensure the Corporate Security Policy states that individuals cannot use the same password on hospital systems as they do on personal systems.
I2-20	**Weak Password Storage**	HIGH	Remove GPOs that contain passwords if not needed. [redacted] which prevents credentials from being stored in Group Policy Objects. Change the password on accounts that had their passwords in these files.
I3-20	**Insecure Storage of Sensitive Information on Shares**	HIGH	Encrypt and restrict access to sensitive information.
I4-20	**Insecure Storage of Sensitive Information on Databases**	HIGH	Ensure appropriate permissions are configured in SQL server on the affected systems.
I5-20	**Default Credentials on Systems and Devices**	HIGH	Ensure default credentials are changed on the affected systems and on any other system before it is placed in production. Changing default passwords should be part of the system hardening process.
I6-20	**Outdated Operating Systems**	HIGH	Decommission or upgrade outdated operating systems. If this is not possible, place on a restricted VLAN with ACLs.

I7-20	**Hosts Vulnerable to EternalBlue Exploit**	HIGH	Install the Microsoft patch MS17-010 on all affected systems.
I8-20	**No Egress (outbound) Port Filtering**	MODERATE	Limit outbound access to only necessary ports and destinations. Have a default deny policy and only allow necessary traffic. Ports such as 80 and 443 (web) can be allowed to all destinations on a firewall, but filtered through a web filtering appliance.
I9-20	**Minimal Segmentation on the Server Network**	MODERATE	Place systems on VLANs according to their data classification. Enable VLAN ACLs to limit access between VLANs.
I10-20	**Unnecessary Administrators**	MODERATE	Review the "Domain Admins" and Workstation Admins" groups and remove accounts that do not need that level of access.
I11-20	**Multipurpose Critical Systems**	MODERATE	Create a separate file server that is not on the domain controller.
I12-20	**Some GPO Objects can be Edited by Anyone**	MODERATE	Review permissions on GPO files and limit access to necessary accounts.
I13-20	**Lenient Web Browsing Policy for Servers**	MODERATE	Perform website filtering for the server network to only allow access to an approved list of websites.
I14-20	**Anonymous FTP allowed**	MODERATE	Disable Anonymous FTP
I15-20	**WPAD Vulnerability & NetBIOS-NS**	LOW	Create a DNS entry for WPAD.root.nih.org. Disable NetBIOS-NS.
I16-20	**Certificate Authority Misconfigurations**	LOW	Generate new certificate requests for the affected systems and sign these certificates with the intermediate authority so they will be trusted on the domain. Remove these certificates from the trusted root authority store.
I17-20	**Public Stored Procedures in SQL**	LOW	Restrict and monitor access to stored procedures.

Wireless Vulnerability Summary

ID	Vulnerability	Risk Level	Resolution
W1-20	**Weak Wireless Passwords**	HIGH	Ensure the guest wireless password is very different from the production passwords. Use complex passwords if pre-shared key is used. Ensure passwords are not guessable and follow corporate policy.
W2-20	**Guest Wireless Segmentation**	LOW	Ensure the guest network cannot be accessed from the production network.

CONCLUSION

Northern Inyo Healthcare has many great security measures in place to prevent attacks. Stern Security was impressed with some of the creative security tactics that are usually only implemented at much larger organizations. There are several high security vulnerabilities that should be addressed in order to prevent compromise. Multifactor (2-factor) authentication should be implemented on external Citrix, Webmail, and VPN portals. The password policy should be updated to require longer and more complex passwords. Permissions should be reviewed for sensitive data on the network. Stern Security highly recommends that Northern Inyo Healthcare fix the noted vulnerabilities in order to prevent similar attacks in the future.

Stern Security would like to thank the Northern Inyo Healthcare for the opportunity to perform this engagement!

Works Cited

NIST. (2012). *Guide for Conducting Risk Assessments 800-30.* National Institute of Standards and Technology.

Ponemon Institute. (2019). *2019 Cost of Data Breach Study: Global Analysis.* Ponemon Institute.

Glossary

Term	Definition
CAPTCHA	A website application that distinguishes humans from machines.
Cleartext Authentication	Authentication that is not encrypted.
DMZ	Demilitarized zone. A network that is a neutral zone between the trusted and untrusted zones. It is usually a network where organizations place servers that will be providing services to the public Internet.
Egress Filtering	Restricting the flow of traffic that is leaving the organization.
Exfiltration	Stealing data out of an organization.
Multifactor Authentication	A system that requires more than one method of authentication. The different methods of authentication are 1. Something you know (e.g. a password or PIN) 2. Something you are (e.g. fingerprint or retina scan) 3. Something you have (e.g. a card, phone, or key fob)
Password Hash	A hash is a one-way function that takes a string such as a password, processes it through an algorithm, and returns a fixed length value called a hash. The password cannot be determined from the hash. The same string always gets the same hash value when processed through the same algorithm.
Phishing	Malicious individual poses as a legitimate company and tricks an individual into giving them sensitive information
Social Engineering	Manipulating a human to gain access to a system.
VPN	Virtual Private Network. A means to securely access internal resources remotely.

NORTHERN INYO HEALTHCARE DISTRICT
PRESENTATION TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: 07/06/2020

Title: ***Implementation of the COVID-19 related distributions provisions of the CARES Act with respect to the Northern Inyo Healthcare District 401(a) Retirement Plan***

Presenter(s): Vinay Behl
Healthcare Finance Consultant

Synopsis:
That the Board of Directors of Northern Inyo Healthcare District direct staff to implement the COVID-19 related distributions provisions of the Coronavirus Aid, Relief, and Economic Security (CARES) Act with respect to the Northern Inyo Healthcare District 401(a) Retirement Plan as specified herein.

EXECUTIVE SUMMARY: Approval of the attached resolution (Attachment 1) will authorize staff to implement certain provisions of the CARES Act in order to help address the economic impacts of COVID-19 that District employees are experiencing. These provisions apply to the Northern Inyo Healthcare District 401(a) Retirement Plan ("401(a) Plan") and will allow qualified participants who are impacted by COVID-19 to withdraw up to a total of $100,000 without having the 20% tax withholding apply or having to pay the 10% early distribution tax, if applicable. Approval of the resolution will also authorize the Chief Executive Officer, or her designee, to sign any necessary amendments to the 401(a) Plan.

FISCAL IMPACT:

DISCUSSION:

The District currently maintains the Northern Inyo Healthcare District 401(a) Retirement Plan ("Plan").

The 401(a) Plan covers all regular, full-time employees who are not eligible to participate in the District's defined benefit plan. The 401 Plan provides nonelective contributions to eligible participants.

There is currently a local, state and national emergency related to the COVID-19 pandemic. This pandemic has resulted in significant economic impacts throughout the nation. As a result, on March 27, 2020, the Coronavirus Aid, Relief, and Economic Security (CARES) Act became law. Among other provisions, the CARES Act provides several options that plans can adopt that can provide some financial relief to participants impacted by COVID-19.

To assist participants impacted by COVID-19 (qualified participants), District staff wishes to propose that the Board of Directors adopt the following recommendations:

Allow qualified participants in the 401(a) Plan to withdraw funds up to a total of $100,000 of their vested accounts under the Plan without the application of the 20% tax withholding that is usually required of in-service distributions and without having to pay the 10% early distribution penalty.

A qualified participant is defined by the CARES Act. As a general summary, it includes participants who were diagnosed with COVID-19, whose spouse or dependent is so diagnosed, or who experiences adverse financial consequences due to COVID-19 (such as being quarantined, being laid off or furloughed, unable to work due to child care, closing or reducing hours of a business, or other factors as determined by the Secretary of the Treasury).

Typically to implement any plan amendments, the IRS requires formal written amendments to the plan documents, which can be a lengthy process. The CARES Act allows immediate implementation of these provisions, as long as the District amends the Plan by the last day of the first plan year beginning on or after January 1, 2024. As such, the attached resolution authorizes the Chief Executive Officer, or her designee, to execute any documents consistent with and necessary to implement these amendments by the deadline in the CARES Act without necessitating further action by the Board of Directors.

In summary, approval of the resolution in Attachment 1 will authorize implementation of the CARES Act with respect to the Plan to allow qualified distributions up to a total of $100,000. It authorizes the Chief Executive Officer, or her designee, to execute all documents consistent with and necessary to implement these provisions and provides up to the last day of the first plan year beginning on or after January 1, 2024 to formally amend the Plan.

Prepared by: VINAY BEHL (ICD)
Vinay Behl

Reviewed by: Executive Team
Name
Title

Approved by: Kelli Davis
Name
Title INTERIM CEO

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: 7-8-2020 Submitted by: Kelli Davis
Chief Officer

NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 20-05

Resolution Approving Implementation the COVID-19 related distributions provisions of the Coronavirus Aid, Relief and Economic Security (CARES) Act with respect to the Northern Inyo Healthcare District 401(a) Retirement Plan and Authorizing Subsequent Amendment of the Plan

WHEREAS, Northern Inyo Healthcare District ("District") previously established the Northern Inyo Healthcare District 401(a) Retirement Plan (the "401(a) Plan") for the benefit of eligible employees and their beneficiaries with an effective date of January 1, 2013; and

WHEREAS, in recent months, the world, including the State of California and the District have been threatened with an unprecedented Coronavirus (COVID-19) pandemic. This deadly virus has impacted every aspect of life and caused financial hardships resulting from lives lost to COVID-19 and loss of jobs. Under the California Governor's Emergency Proclamation of March 4, 2020, closure of non-essential businesses was ordered to slow the rapid spread of COVID-19; and

WHEREAS, the Coronavirus Aid, Relief, and Economic Security (CARES) Act was enacted and allows qualified participants affected by COVID-19 the option to withdraw a total of up to $100,000 from their vested accounts under the 401(a) Plan; and

WHEREAS, to offer this withdrawal option to qualified 401(a) Plan participants, amendments to the 401(a) Plan documents are required, but the CARES Act allows implementation prior to the formal amendments which must occur by the last day of the first plan year beginning on or after January 1, 2024; and

WHEREAS, the District's Board of Directors wishes to implement the withdrawal option under the CARES Act as set forth above.

NOW, THEREFORE BE IT RESOLVED by the Board of Directors of Northern Inyo Healthcare District:

1. The Chief Executive Officer, or her designee, is hereby authorized to implement the following Plan amendments in accordance with the CARES Act effective immediately:

   Allow qualified participants in the 401(a) Plan to withdraw funds up to a total of $100,000 of their vested accounts without the application of the 20% tax withholding that is usually required of in-service distributions and without having to pay the 10% early distribution penalty.

2. The Chief Executive Officer, or her designee, is authorized to execute any documents consistent with and necessary to implement these provisions immediately and is hereby directed to prepare and execute the necessary Plan amendments to the 401(a) Plan by the deadline set forth in the CARES Act.

_____ _____

District Board Secretary
Northern Inyo Healthcare District

Date

APPROVED AS TO FORM AND CONTENT:
BEST BEST & KRIEGER, LLP
By:_____
Attorneys for Employer

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Pension Funding Policy	
Scope: Accounting	Department: Fiscal Services
Source: Chief of Fiscal Services	Effective Date: 6/__/2020

Purpose:

To assure timely funding of 401(a) Employee Defined Contribution Pension Plan and Defined Benefit Plans.

Policy:

According to the plan document, the District will work with the plan actuary to determine amounts necessary for funding of the 401(a) Defined Contribution Plan by IRS deadlines.

The Actuary will provide the funding timeline annually for the Defined Benefit Plan during the annual plan report. The Actuary will determine the recommended contribution for the Defined Benefit Plan for the plan year and will provide information about both the Normal Cost and the Unfunded Accrued Liability (UAL).

The funding recommendations for both the 401(a) Defined Contribution Plan and the Defined Benefit Plan will be presented to the NIHD Board of Directors for approval.

For a twenty-four month period after the Proclamation on Declaring a National Emergency concerning the Novel Coronavirus Disease ("COVID-19") Outbreak ("COVID-19 National Emergency") signed by the President of the United States on March 13, 2020, the NIHD Board of Directors may decide not to fund the recommended contribution for the Defined Benefit Plan, but instead fund an amount which shall be no less than the Normal Cost for the Plan Year.

Procedure:

1. After calendar year W-2 Statements have been processed and issued, Payroll will create the year-end Pension Data files.
2. Accounting and Human Resources will work to develop the pension data files for each of the two pension plans, defined contribution and defined benefit, using the format provided by the actuary.
3. Accounting will work with the designated pension actuaries and advisors to submit the data for the defined contribution and defined benefit plans by agreed upon time-frames.
4. The Actuary will notify Northern Inyo Healthcare District of the recommended Defined Benefit Plan amount to be funded, but will also separate the amount into the Normal Cost and the UAL components.

Title: Pension Funding Policy	
Scope: Accounting	Department: Fiscal Services
Source: Chief of Fiscal Services	Effective Date: 6/__/2020

5. We will review and seek Board approval to fund the appropriate amount as soon as possible but not later than the IRS deadline for pension plan funding of October 15 of the following year.

6. For a twenty-four month period after the Proclamation on Declaring a National Emergency concerning the COVID-19 National Emergency was signed by the President of the United States on March 13, 2020, the NIHD Board of Directors will decide the amount to fund for the Defined Benefit Plan, which amount shall be no less than the Normal Cost determined by the Actuary for the Plan Year.

Committee Approval	**Date**
Administration	
Board of Directors	

Responsibility for review and maintenance:
Index Listings:
Developed: 6/___/2020
Revised:
Reviewed:

AMENDMENT NO. 5
TO THE
NORTHERN INYO HEALTHCARE DISTRICT RETIREMENT PLAN

RECITALS

A. The NORTHERN INYO HEALTHCARE DISTRICT ("Employer"), adopted the NORTHERN INYO HEALTHCARE DISTRICT RETIREMENT PLAN (the "Plan") for the benefit of its Employees and their Beneficiaries, effective as of March 1, 1975, and subsequently amended and restated the Plan as of January 1, 2009.

B. On March 13, 2020, a Proclamation on Declaring a National Emergency concerning the Novel Coronavirus Disease ("COVID-19") Outbreak ("COVID-19 National Emergency") was signed by the President of the United States of America.

C. The Employer desires to amend the Plan effective as of March 13, 2020 to provide flexibility to the Employer in carrying out the funding policy under the Plan as result of the COVID-19 National Emergency.

D. Section 8.1 of the Plan provides that the Employer reserves the right to amend the Plan at any time.

AMENDMENT

NOW, THEREFORE, effective as of March 13, 2020, the Employer hereby amends SECTION VII of the NORTHERN INYO HEALTHCARE DISTRICT RETIREMENT PLAN to add the following before the last sentence of section 7.1:

> Notwithstanding the foregoing, for a twenty-four month period after the Proclamation on Declaring a National Emergency concerning the Novel Coronavirus Disease ("COVID-19") Outbreak ("COVID-19 National Emergency") signed by the President of the United States on March 13, 2020, the Employer shall make contributions in accordance with the funding policy but not less than the normal cost rate for the Plan in accordance with section 7522.52 of the California Government Code, as determined by the Actuary for the Plan Year.

IN WITNESS WHEREOF, the Employer has caused this amendment to be executed on June ___, 2020.

EMPLOYER:

NORTHERN INYO HEALTHCARE DISTRICT

By:_____

Title: _____

APPROVED AS TO FORM AND CONTENT
BEST BEST & KRIEGER LLP

By:_____

Attorneys for Employer

NORTHERN INYO HEALTHCARE DISTRICT
RECOMMENDATION TO THE BOARD OF DIRECTORS
FOR ACTION

Date: 7/3/2020

Title: **BOARD RESOLUTION 20-~~05~~ 06 APPROVAL OF APPROPRIATIONS LIMIT**

Synopsis: It is recommended that the Board of Directors approve and adopt the Resolution to establish an annual appropriations limit in accordance with Article XIIIB of the California Constitution. As a government entity, NIHD is to receive funds from property taxes in the form of State Appropriations. These funds are for operating expenses and are not restricted as to use.

Prepared by: _____
Name Jennifer Owens
Title Controller

Reviewed by: EXECUTIVE TEAM
Name
Title of Chief who reviewed

Approved by: Kelli Davis
Name
Title of Chief who approved INTERIM CEO

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Acceptance: 7/8/2020 Submitted by: Kelli Davis
Chief Officer

NORTHERN INYO HEALTHCARE DISTRICT
DISTRICT BOARD RESOLUTION 20-06

WHEREAS, the Northern Inyo Healthcare District is required to establish an annual appropriations limit in accordance with Article XIIIB of the California Constitution; and

WHEREAS, using data provided by the State of California Department of Finance, on June 19, 2019, the Board of Directors of Northern Inyo Healthcare District established an appropriations limit of $651,078.09 for the July 1, 2019 to June 30, 2020 fiscal year; and

WHEREAS, using the attached data provided by the State of California Department of Finance and the County of Inyo, an appropriations limit of $677,524.23 has been calculated for the July 1, 2020 to June 30, 2021 fiscal year.

NOW, THEREFORE, BE IT RESOLVED by this Board of Directors of Northern Inyo Healthcare District, meeting in regular session this 15th day of July, 2020 that an appropriations limit of $677,524.23 be established for the Northern Inyo Healthcare District for the 2020-2021 fiscal year; and

BE IT FURTHER RESOLVED that this Resolution be made a part of the minutes of this meeting.

Adopted, signed and approved this 15th day of July, 2020.

_____
District Board Chair

_____
District Board Secretary

Appropriation calculation:

Per capita personal income 3.73

Per capital cost of living converted to a ratio:	$\frac{3.73+100}{100} = 1.0373$
Population minus exclusion:	+0.10
Population converted to ratio:	$\frac{0.22+0.10+100}{100} = 1.0032$
Calculation of factor for FY 2018-19:	1.0373x1.0032=1.040619

Prior year appropriation limit: $604,858.24

Calculation of appropriation limit for FY 2019-20: $651,078.09x1.040619=$677,524.23

DEPARTMENT OF FINANCE
OFFICE OF THE DIRECTOR

GAVIN NEWSOM - GOVERNOR
STATE CAPITOL ■ ROOM 1145 ■ SACRAMENTO CA ■ 95814-4998 ■ WWW.DOF.CA.GOV

May 2020

Dear Fiscal Officer:

Subject: Price Factor and Population Information

Appropriations Limit
California Revenue and Taxation Code section 2227 requires the Department of Finance to transmit an estimate of the percentage change in population to local governments. Each local jurisdiction must use their percentage change in population factor for January 1, 2020, in conjunction with a change in the cost of living, or price factor, to calculate their appropriations limit for fiscal year 2020-21. Attachment A provides the change in California's per capita personal income and an example for utilizing the price factor and population percentage change factor to calculate the 2020-21 appropriations limit. Attachment B provides the city and unincorporated county population percentage change. Attachment C provides the population percentage change for counties and their summed incorporated areas. The population percentage change data excludes federal and state institutionalized populations and military populations.

Population Percent Change for Special Districts
Some special districts must establish an annual appropriations limit. California Revenue and Taxation Code section 2228 provides additional information regarding the appropriations limit. Article XIII B, section 9(C) of the California Constitution exempts certain special districts from the appropriations limit calculation mandate. The code section and the California Constitution can be accessed at the following website: http://leginfo.legislature.ca.gov/faces/codes.xhtml.

Special districts required by law to calculate their appropriations limit must present the calculation as part of their annual audit. Any questions special districts have on this requirement should be directed to their county, district legal counsel, or the law itself. No state agency reviews the local appropriations limits.

Population Certification
The population certification program applies only to cities and counties. California Revenue and Taxation Code section 11005.6 mandates Finance to automatically certify any population estimate that exceeds the current certified population with the State Controller's Office. **Finance will certify the higher estimate to the State Controller by June 1, 2020.**

Please Note: The prior year's city population estimates may be revised. The per capita personal income change is based on historical data. Given the stay-at-home orders due to COVID-19, growth in the coming years may be substantially lower than recent trends.

If you have any questions regarding this data, please contact the Demographic Research Unit at (916) 323-4086.

/s/ Keely Martin Bosler

KEELY MARTIN BOSLER
Director

Attachment

A. **Price Factor**: Article XIII B specifies that local jurisdictions select their cost of living factor to compute their appropriation limit by a vote of their governing body. The cost of living factor provided here is per capita personal income. If the percentage change in per capita personal income is selected, the percentage change to be used in setting the fiscal year 2020-21 appropriation limit is:

Per Capita Personal Income

Fiscal Year (FY)	Percentage change over prior year
2020-21	3.73

B. Following is an example using sample population change and the change in California per capita personal income as growth factors in computing a 2020-21 appropriation limit.

2020-21:

Per Capita Cost of Living Change = 3.73 percent
Population Change = 0.22 percent

Per Capita Cost of Living converted to a ratio: $\frac{3.73 + 100}{100} = 1.0373$

Population converted to a ratio: $\frac{0.22 + 100}{100} = 1.0022$

Calculation of factor for FY 2020-21: $1.0373 \times 1.0022 = 1.0396$

Attachment B
Annual Percent Change in Population Minus Exclusions*
January 1, 2019 to January 1, 2020 and Total Population, January 1, 2019

County City	Percent Change 2019-2020	--- Population Minus Exclusions --- 1-1-19	 1-1-20	Total Population 1-1-2020
Inyo				
Bishop	0.16	3,815	3,821	3,821
Unincorporated	0.09	14,666	14,679	14,763
County Total	0.10	18,481	18,500	18,584

*Exclusions include residents on federal military installations and group quarters residents in state mental institutions, state and federal correctional institutions and veteran homes.

NORTHERN INYO HEALTHCARE DISTRICT

RESOLUTION NO. 20-07

RESOLUTION AUTHORIZING THE COMMENCEMENT OF PROCEEDINGS IN CONNECTION WITH THE PROPOSED ISSUANCE OF BONDS TO REFUND THE DISTRICT'S OUTSTANDING NORTHERN INYO COUNTY HOSPITAL DISTRICT (INYO COUNTY, CALIFORNIA) REVENUE BONDS, SERIES 2010, AND DESIGNATING A MUNICIPAL ADVISOR, BOND COUNSEL AND A PLACEMENT AGENT IN CONNECTION THEREWITH

RESOLVED, by the Board of Directors (the "Board") of the Northern Inyo Healthcare District, a California local health care district (the "District"):

WHEREAS, the District proposes to issue bonds (the "Bonds") to refund its outstanding Northern Inyo County Hospital District (Inyo County, California) Revenue Bonds, Series 2010 (the "2010 Bonds"), in order to reduce the District's annual debt service payments with respect to the 2010 Bonds ; and

WHEREAS, it is appropriate that the Board formally authorize commencement of proceedings, to appoint a municipal advisor, bond counsel and a placement agent and to approve certain preliminary actions in connection with the execution and delivery of the Bonds; and

NOW, THEREFORE, it is hereby ORDERED and DETERMINED, as follows:

Section 1. The Board authorizes appropriate officers and officials of the District to proceed with the preparation of the necessary documents in connection with the issuance and sale of the Bonds, subject to the final approval thereof by the Board at a subsequent meeting.

Section 2. H. G. Wilson Municipal Finance Inc. is hereby designated as municipal advisor (the "Municipal Advisor") to the District in connection with the issuance, sale and delivery of the Bonds.

Section 3. Quint & Thimmig LLP is hereby designated as bond counsel to the District in connection with issuance, sale and delivery of the Bonds.

Section 4. The Municipal Advisor is hereby authorized to identify a placement agent to the District in connection with the issuance, sale and delivery of the Bonds following a competitive process.

Section 5. All actions of the officers, agents and employees of the District that are in conformity with the purposes and intent of this resolution, whether taken before or after the adoption hereof, are hereby ratified, confirmed and adopted.

Section 6. The Chair of the Board, the Vice Chair of the Board, the Chief Operations Officer/Interim Chief Executive Officer, the Secretary of the Board and other appropriate officers and officials of the District are hereby authorized and directed to take such action and to execute such documents as may be necessary or desirable to effectuate the intent of this resolution.

Section 7. This resolution shall be in full force and effect immediately upon its adoption.

* * * * * * * * *

I hereby certify that the foregoing resolution was duly adopted at a meeting of the Board of Directors of the Northern Inyo Healthcare District held on the ____ day of _____, 2020, by the following vote:

AYES, and in favor of, Board Members:

NOES, Board Members:

ABSENT, Board Members:

By _____
Secretary

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title:	
Scope: Nursing Services	Manual:
Source: CNO	Effective Date: 11/1/14

PURPOSE:

1. Nursing standards are developed to describe and guide how the nursing care needs of patients and/or patient population are assessed, evaluated and met including the competency of the staff.
2. This policy and procedure addresses the systematic process including the Chief Nursing Officer (CNO) accountability and responsibility for nursing standard development, review, revision, approval and implementation.

POLICY:

1. The CNO has ultimate authority for the oversight of Nursing Standards.
2. The CNO in collaboration with the Director's/Managers of Nursing, District Education Coordinator, House Supervisors, Clinical Informatics, develops the structure standards located in the Nursing Administration Manual (NAM).
3. The Directors of Nursing have been delegated the authority to lead the process for the review of direct patient care process standards including Policies and Procedures (P&P), Forms, and Standards of Practice (delegated and independent). Prior to implementation assurance of consistency with the NIHD Mission, Vision, Values and Goals, evidence based practice, legal and ethical considerations and responsiveness to performance improvement and other evaluation mechanisms is required.
4. The Clinical Consistency Committee is responsible for assuring collaboration and involvement with other disciplines and seeking Medical Staff Committee approval where necessary (follow NIHD Hospital Policy and Procedure)
5. The DON/Manager is responsible for developing, reviewing and revising Nursing Standards of Care (what the patient/family can expect) for their department or patient population (see attachment A1 and A2). Other standards of Care may be developed for patient populations that may be care for in greater than one department i.e. Care of the Dying.
6. Nursing Standards of Practice describe activities that define nursing expectations that nursing staff perform to provide the realms of nursing practice (delegated, independent and interdependent) to patients and their significant others.
    a. The delegated and independent realms of nursing practice are reflected in the care plans developed for the patient's clinical diagnosis.
    b. The interdependent realms of practice are reflected in the Disease Specific Order Sets.
7. Interdisciplinary P&P's (assure one level of care and apply to more than one department) serve as the procedure guideline to provide patient care based on the standards of care/practice and designated by the scope of who can perform the P&P.
8. Department and/or Service Line specific P&P's (assure one level of care and apply to one department only or a service line) and are located in the Departments (Structures/Process Standards) Manual within the electronic policy application found on the NIHD intranet.
9. The Hospital Policy and Procedure format is the template utilized for developing all P&P's. The Policy Steering Committee has oversight of format development utilized within the NIHD policy application.
10. A Nursing Services Overall Position Skills Checklist (based on job description, licensure, practice, procedures, certification, and training) is utilized upon hire of all new personnel.
11. Up to Date is utilized as a reference for all nursing units and specialties in addition to American Nursing Association Scope and Standards of Practice for each specialty area. Additionally, The Joint Commission Standards, including elements of performance, are followed.
12. Job Descriptions reflect broad competency statements of what the employee must know in the performance of the employee's job.

   a. Performance standards specify what the employee must be able to demonstrate to meet the competency statement.
   b. A Job Description Clinical Skills Checklist, utilized for competency validation, exists for each position responsible for direct patient care.
13. Forms (to for downtime) will be developed reflective of the electronic medical record (EMR) that reflects the nursing process (delivery of care) for the specific patient population.
14. Required review or revision of Structures and Process Standards no less than every three years.
   a. Changes in practice based on research, new technology, changing populations, performance improvement, risk reduction / safety information will direct the review and modification of structures / process standards.
15. New Process Standards that involve multiple disciplines require collaboration for development.
16. Structure and Process Standards will be available on the NIHD intranet Policy Manual application.
17. *OneSOURCE* is a reference for clinical equipment.

Definitions:

1. Structure Standards: Define the foundation for all the conditions and mechanisms needed to operate a nursing system.
   a. Generic Nursing Structure Standards are written plans, policies and/or procedures and are located in the Nursing Administration section of the policy manual application.
   b. Department Specific Structure Standards are written plans, policies and/or procedures and are located in the Department Specific area within the policy manual application.
2. Process Standards: Define the actions, knowledge, and skills needed by nursing in the delivery of care and what constitutes that care. Process standards have been categorized into five formats:
   a. Policy and Procedures;
   b. Forms;
   c. Standards of Care;
   d. Standards of Practice; and
   e. Job Descriptions

PROCEDURE:

1. Staff may request a Process Standard Development review or revision working with nursing leadership.
2. Procedures may be utilized Lippincott Procedure Manual in lieu of development of procedure. Critical notes applicable to NIHD practice will be included as necessary.
3. Use of approved clinical reference manuals for nursing procedures not described in the NIHD policy manual application is acceptable.
   a. See attachment C; Nursing Services Reference List
   b. All NIHD info-bases will supersede information given in the reference manuals.
   c. Approved Reference Manuals will be located in all nursing departments.
4. The Clinical Consistency Oversight Committee (CCOC) will oversee the approval of Nursing Policy and Procedure. Anyone developing a draft Policy and Procedure will send the document to the CCOC Chair for member oversight. The CCOC member or designee will request additional feedback from risk management, compliance officer and/or other committees for approval.
   a. See charter of CCOC listed in policy manual application
5. The department/ or job specific clinical staff educator will ensure that competency check off is completed via one of the list below:

   a. Use Competency Validation Form to validate skills completion;
   b. Policy Manager Review;
   c. Learning Management System review and testing process
6. After staff education, the effective date on the Policy Procedure will indicate the Policy and Procedure goes into effect. Until that time, the policy remains in draft.

Review/Revision of Policy and Procedure

1. Policies and Procedures will have a "source" listed by job role. This role has responsibility to review, revise or recommend archival.
2. Policies and Procedures will be reviewed every three years with the following considerations:
   a. Is the Policy and Procedure still relevant to clinical practice or patient population at NIH?
   b. Is the Policy and Procedure high risk, problem prone, high/low volume, high cost? How often is the staff reassessed or the competency of the skill if all four criteria are present?
   c. Any ethical of legal concerns?
   d. Does it meet current research or state/national standards?
   e. Consideration of findings from quality assurance/performance improvement and other evaluation mechanisms have been reviewed.
3. Policy and Procedures that involve collaboration with other disciplines shall be developed together.
4. Policy and Procedure is maintained via computerize policy manual application.

Other

1. Every year, each policy is reviewed by the Board of Directors.

REFERENCES:

1. CAMCAH 2019, TJC Nursing Functional Chapter, NR 02.01.01 and NR 02.03.01

CROSS REFERENCE P&P:

1. OneSource
2. NIHD Policy & Procedure Development
3. Nursing Standing Committees

Approval	**Date**
NEC	7/1/2020
Board of Directors	10/14
Last Board of Director review	4/18/18

Developed: 8/13
Reviewed:
Revised: 5/14, 6/2020ta

ROI COMMITTEE

Membership: Kelli Davis, Tracy Aspel, Dr Will Timbers, Vinay Behl

Clinical

	Service Line/Contract	Projected Cost/Revenue	Realized	Decision	STATUS
1	NEST Program	$ 250,000.00		NEST program to be terminated and positions eliminated. Cost Savings:	Program terminated effective August 1, 2020
2	Urologist	$ 120,000.00		Plan to renegotiate provider contract	Contract renegotiated to stop loss
					High overhead resources compared to direct costs. Overheads not pooled with NIHD despite full ownership resulting in heavy losses.
3	Pioneer Home Health	$ 200,000.00		Plan to integrate PHH in the overall NIHD model to save ovrhead costs and get economies of scale	Unauthorized position not approved in budget
4	Pioneer Medical Associates	$ 204,000.00		Present a plan to purchase building, result in savings in rent	Building Appraisal in progress
5	Plastic Surgeon	$ 100,000.00		Analyzing additional service line	offer extended
6	Ortho Spine Surgeon			Analyze additional service line for 1-2 days a month pilot	Evaluation in progress
7	Marriage Family Therapist			Analyze additional service line , enable higher billing under medi-cal from $ 270 per visit to $ 330 per visit	Hiring in progress
8	Bronco Clinic			Analyze terminating the program and restructuring with revenue element	Evaluation in progress
9	Pharmacy on call model			Analyze possibility of in attendance medical staff to perform certain pharmacist functions to avoid additional pharmacist time	
10	Radiology renegotiation				Evaluation in progress
11	APP surgery				Evaluation in progress
12	Pain management Clinic	$ 150,000.00			offer extended
13	ENT				Dr Timbers WIP
14	Dermatology				TBD
15	Pscychologist				
16	Occupational medicine				
17	Rewrite RHC Contract				Recruitment posting
	Wound care				Compensation model
					TBD
		$ 1,024,000.00	$ -		Dr Leja full time wound care/PCP

Administrative

	Service Line/Contract				
1	Bond refunding	$ 800,000.00		Reduce debt service costs to reduce cash outflow per year	Process started with Appointment of Financial advisor
2	Benefit plans	$ 250,000.00		Review all benefit plans and investment portfolio	Evaluation in progress
3	Medical Plans	$ 250,000.00		review medical plan with no impact to benefits	Two brokers appointed for review Verus Insurance & Robert C placak & Associates
4	Provider Compensation database			Benchmark provider compensation and review every service line for profitability	Evaluation in progress
5	Lease financing contract			Negotiating with Meridian leasing to enable capital budget purchase through financing	Completed
6	Audit Fees	$ 125,000.00	$ 135,000.00	Renegotiate independent auditor contract resulting in $ 100-125k savings over 5 years	Completed
7	ADP -Payroll Provider Contract	$ 25,000.00			Completed
8	Omnicell medicine dispensing Cabinets	$ 75,000.00	$ 75,000.00	Renegotiated medicing dispensing cabinet contract for further discount of $ 75k	Completed
9	Capital budget			Approved $ 1.2 million cap budget with all items to be financed and build in $ 500k unplanned expenditure budge	Completed
10	Contract with Anthem for transporting medi-cal patients				Completed, Evaluation after 6 months
11	Investment of cash				Evaluation in progress
12	Intuitive Surgical Inc agreement				Evaluation in progress
13	Revenue cycle comprehensive audit				Negotiating terms with UASI
16	Athena EHR law suit strategy				Evaluation in progress
17	Community Hospital Corp GPO supply chain				Evaluation in progress
18	Colombo Architect proposal				Evaluation in progress
19	Telepsych Contract				Evaluation in progress
20	HCIN spanish call center				Evaluation in progress
		$ 1,525,000.00	$ 210,000.00		

NIHD Board Meeting 07/15/20
Quarterly Report from Pioneer Home Health Care, Inc.
Ruby Allen RN, Administrator

While our June totals are not in yet, we can summarize our May information and add some of the June highlights.

Program Summaries

A. Home Health Care
   1. Referrals are up! In June, home health had 32 referrals – we haven't had this many referrals in a month since 2016.
   2. Through June end, we have provided 929 visits (averaging 155 home visits per month)
   3. Because we service from Lone Pine to June Lake, and on to Benton (up Highway 6) we are averaging approximately 17 miles per home health visit
   4. Present number of active patients = 44. This is a 100% increase since June last year. And, we served an all-time high of 51 patients at one point last month.
   5. Medicare changed their home health payment system at the beginning of 2020. PHHC has been utilizing the new PDGM reimbursement system for home health services for a full 6 months now. The reimbursement rates appear to be better than the previous PPS payment system. Billing and accounting for this new payment system however is incredibly more time consuming for both our biller and financial person, but the fact that we are receiving a bit more for our services is very encouraging

B. Hospice Program
   1. Have served 15 hospice patients this year
   2. Average length of stay (LOS) = 39 days
   3. Miles traveled = 3,597 – average 30.74 miles per Hospice visit
   4. Community Bereavement Support Group was cancelled due to COVID-19, but will be rescheduled when things improve. However we continue to provide bereavement services to the loved ones left behind.
   5. Hoping to restart the volunteer program, and train new volunteers, and obtain more community involvement.

C. Personal Care Program – privately paid by client
    1. 10,365 hours of attendant care has been provided this year in our community, totaling 465 hours per week. This is a 25% increase over last year.
    2. We presently have 25 active clients and 18 caregivers
    3. We have recently changed our advertising in order to recruit more caregivers and clients.
    4. Currently we have a waiting list for new clients.
    5. Vet Assist Program: PHHC is now in the process to be listed as a contracted agency to provide "Aide and Attendance" for our qualifying local veterans. This will benefit our veterans as well as provide additional work for the Personal Care Program.

Benefit payment changes

Up until May, we had a small flat rate per employee for health benefits that was parallel to NIHD. When PHHC partnered with the Northern Inyo Hospital District, we were able to enroll our employees in a benefit-rich, low deductible and low out-of-pocket Blue Shield health plan. And at the same time, the employee-paid amount for this great insurance went down considerably per the "parallel" and pay rates went up considerably. After almost a year and a half, we now see that PHHC could not sustain all three of these changes at the current level.

In response, the PHHC board agreed to return to our previous employer/employee payment split to where the company pays 80% and the employee pays 20% of their health/dental and vision benefits. This provides a significant savings to the agency in the amount of $16,922.00 over a year. But these changes also mean that we no longer parallel the benefits of NIHD. Again, the goal of partnering with the district was to parallel the benefits in order to attract/retain employees that would be retained by a flexible work environment, as well as excellent benefits. Current health insurance package is excellent, and the jump from the flat fee to the 20% across the board, was a fair way to reduce the costs of health benefits for the agency but not too significantly high for the employee. We continue to match pay rates/salaries to NIHD.

Grants and Fundraising

PHHC received a $2,300 COVID grant from the Bishop Chamber of Commerce.

Also, through various fundraising efforts, $2,100 was raised as well.

The general grant search continues, utilizing a program PHHC purchased many years ago. It expires early August so we are gathering data on all appropriate foundations, potentially interested in working with us. We have one person dedicated to the search, with a focus on rural and frontier community needs. Previous Administrator, Pat West, is working as senior advisor and will be involved in writing the inquiry letters in which she has experience. We are also looking for seed money to cover thrift shop startup costs as per our strategic plan from 2019.

CARES (Coronavirus Aid, Relief, and Economic Security Act) monies ($43, 966.30) were received in April. We have sent the required acknowledgement that we received the funds. Originally there were no strings attached, no requirements, however now there appears to be stipulations as to how the money can be used, and we are working on how to address this.

In June, we applied at Eastern Sierra Community Bank and were approved for a low interest Paycheck Protection Program (PPP) loan originally in the amount of $343,706.20, which has since been recalculated to $290,951.00. This money is specifically designated to help with payroll expenses, taxes, employee benefits, mortgage interest and utilities during the next 2.5 months. We have begun to keep very detailed records on how this money is being spent so we can qualify for forgiveness of this loan.

At the beginning of June, we had an incident with an employees' mobile payroll deposit, where copies were made of the payroll check by unknown suspects and several attempts were made to pass counterfeit checks. This issue was caught promptly and the payroll account has been closed. All employees were instructed in financial safety/integrity when using mobile banking. No loss was incurred.

At the end of May:
Home Health Program shows a net of $145,239.80
Hospice Program shows a net of $27,361.86

Personal Care Program shows a net loss of $40,529.76. This particular program has continually shown a loss due to the paralleling of salaries with NIHD in September 2018.
Overall, the entire agency shows a net income of $132,071.90 for 2020 January through May.

Employee Changes

PHHC is in need of a Biller/Office, Clerical Person, MSW Social Worker, PT or PTA per diem, and CNA's interested in taking our 40 hour class in order to qualify for CHHA (Certified Home Health Aide) a requirement to work in the home arena. We were able to fill the Hospice Chaplain role with Patrick Thompson, for which we are grateful.

We have been working without the clinical supervisor role saving $98,000.00 a year, and have fully retired Pat West of her administrator role. However, she is now serving in her new role as the Senior Advisor, and will also fill the Corporate Compliance role per PHHC Board direction at the May PHHC Board meeting. Still working on SIHD contract for contracted rehab services in the Southern Inyo area.

Strategic Plan for 2019 - 2024

Staff reviewed the plan and it was noted that significant progress has been made in meeting goals initially set in 2019.

General Community Reach Out

Have improved communication with Mammoth Hospital, General Population Health, and Family Med Clinic for home health and hospice referrals.

Have also been working with SIHD and increased communication with the Southern Inyo Hospital Clinic, with education re Home Health and Hospice referrals.

Have met with the director of nursing and discharge planner at Bishop Care Center, and PHHC is now receiving regular referrals for Home Health Care from the facility.

Sending out educational materials about our services to the various rehab and acute care settings in Gardnerville, Minden, Carson City and Reno in an effort to provide our services to those in our community that have been provided out of area services, and are now returning home.

We continue to work well in collaboration with NIH Care Coordination and Discharge planning, to provide safe transitions of care.

Overall, PHHC is optimistic about the future and appreciative of our past, current and continuing partnership with NIHD.

NORTHERN INYO HEALTHCARE DISTRICT
One Team. One Goal. Your Health.

NORTHERN INYO HOSPITAL
Northern Inyo Healthcare District
150 Pioneer Lane, Bishop, California 93514

Medical Staff Office
(760) 873-2136 voice
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TO: NIHD Board of Directors
FROM: Stacey Brown, MD, Chief of Medical Staff
DATE: July 7, 2020
RE: Medical Executive Committee Report

The Medical Executive Committee met on this date. Following careful review and consideration, the Committee agreed to recommend the following to the NIHD Board of Directors:

A. Annual Approvals (*action items*)
   1. *Standardized Procedure – Certified Nurse Midwife*
   2. *Standardized Procedure – General Policy for the Nurse Practitioner or Certified Nurse Midwife*
   3. *Utilization Review Plan (2020)*

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standardized Procedure - Certified Nurse Midwife	
Scope: Perinatal, Surgery	Manual: Perinatal - Standards of Practice Independent/Interdependent
Source: ~~OB Nurse Manager~~Medical Staff Support Manager	Effective Date: 1/18/17

I. POLICY

A. Definition and Purpose:
The nurse midwife, by virtue of added knowledge and skill gained through an organized program of study and clinical experience recognized by the American College of Nurse-Midwives, practices in the area of management of care of ~~mothers.~~pregnant women, so long as progress meets the criteria accepted as normal. Nurse-Midwives are educationally prepared to recognize the deviations from normal at a time when medical care can be instituted to safeguard the ~~well being~~well-being of the ~~mother~~ patient and baby. The practice of nurse-midwifery is recognized as an extended role for specially trained nurses under the Nursing Practice Act, as used in the following policies and protocols:

1. Nurse-midwife, means a registered nurse certified to practice nurse-midwifery pursuant to the Nursing Practice Act (Art. 2.5, Ch 6, Div. 2 Secs 2746-2746.51, business and professional Code and related to regulations (Sections 1460-1466 Title 16 California Adm. Code)).
2. Supervising Physician, means a physician who is an active member of the medical staff at Northern Inyo Hospital and who has current obstetrical privileges. This individual must contract with the practicing nurse-midwife to supervise normal obstetrical patient care. ~~All patients will be admitted to the supervising physicians service.~~
3. "Normal delivery" means vertex presentation, vaginal birth of a child, completed by the natural efforts of the mother. Criteria and Exclusions: refer to addendum A attached.

B. Experience, training and/or education criteria for Nurse Midwives:
Criteria: Applicants for membership and privileges as a nurse-midwife shall meet the following criteria:

1. Licenses: Possession of a valid California license as a registered nurse. Possession of a valid California license as a certified nurse midwife. Board certified by the American Midwifery Certification Board (AMCB) within one year of graduation from an accredited school of nurse-midwifery.
2. Education: Graduation from an accredited certified nurse midwife program.
3. Experience:
   a. New Graduates: Completion of a post graduate internship in a university affiliated setting or in a setting approved by the chief of obstetric services. ~~If more than 24 months since graduation, CNM may be required to fulfill a remediation course.~~
   b. Experienced CNM: In lieu of the required internship, an experienced CNM may furnish documentation of 1-2 years of recent hospital based intrapartum management experience in either a university setting or in affiliation with a board certified obstetrician/gynecologist or family practice physician.
   ~~b.~~c. For CNM that cannot demonstrate current competence (experience in last 24 months) refer to applicable practitioner re-entry policy.
5. Maintain American Midwifery Certification Board Continuing Competency and Assessment (CCA). Verification in the Certified Nurse Midwife credential file.

6. ~~Perinatal Committee~~Departmental and/or perinatal meeting attendance as determined by the Chief of Obstetrical Services.
7. CNM's who request privileges to assist at Cesarean Section Deliveries must meet the following educational and performance criteria:
   a. Successful completion of a course in CNM First Assisting for Cesarean Sections through an accredited college, or a program approved by the ACNM or Chief of Obstetrical Services, that incorporates didactic and clinical performance sections.
   b. The CNM will be proctored for minimum of 2 second assists and 3 first assists at Cesarean Sections and/or for a minimum of 3 months, at which time the Chief of Obstetric Services will recommend either an extension of the proctoring period or approval for Cesarean Section First Assistant privileges to the Interdisciplinary Practice Committee.
   c. Continued competency will be reviewed by the Chief of Obstetrical Services on an annual basis by direct observation of performance and he/she will then make a recommendation for approval or denial of continued privileges through the credentialing process to the Interdisciplinary Practice Committee.
   d. Refer to appendix B for complete description of CNMFA scope and qualifications.
8. Application requirements for staff privileges, in addition to the above will include
   a. The certified nurse-midwife will be required to carry liability insurance
   b. The certified nurse-midwife will agree not to participate in out of hospital births
9. Successful completion of ~~CPR~~ BLS and ~~neonatal resuscitation~~NRP are required; successful completion of ACLS ~~and PALS~~ is preferred.

C. Probationary/Proctoring Period.
   1. The period of observation will be no less than 3 months and will be used for evaluation of midwifery skills. A new graduate will be required to have a total of 10 supervised deliveries by a designated proctor to receive hospital privileges. A midwife with greater than 2 years of documented experience will be required to have 5 supervised deliveries.
   2. Observation will be performed by: supervising physician, other CNMs with current staff privileges, chart review, as well as assessment of obstetrician/gynecologists.
   3. CNM Cesarean Section First Assistant: proctoring period as described under section "B" above

D. Nurse Midwife Functions:
   1. Function as member of the obstetrical team under supervision and guidance of a supervising physician. Arrange for alternate consultation if supervising physician not available
   2. Manage labor, delivery and postpartum course of normal obstetrical patients and/or deliver care to normal newborn under the auspices of supervising physician and may co-manage exclusions with physician present
   3. Function in the role as First Assistant for Cesarean Sections when requested by an obstetrician-see complete description under appendix B.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standardized Procedure - Certified Nurse Midwife	
Scope: Perinatal, Surgery	Manual: Perinatal - Standards of Practice Independent/Interdependent
Source: ~~OB Nurse Manager~~Medical Staff Support Manager	Effective Date: 1/18/17

II **GUIDELINES:**

A. Intrapartum Care by Nurse Midwife:
   1. A Certified Nurse Midwife may function under the confines of their own "Scope of Practice" as defined by the American Midwifery Certification Board. All of the above functions are to be performed within the parameters of normal. If problems arise, the supervising physician is to be notified immediately, as well as the pediatrician, if indicated.
   2. Medication orders are to be signed by the supervising physician unless prescribed under the approved medication listed. "see list"

B. Resuscitation of newborn:
   1. Routine stabilization/care of the newborn at delivery following the guidelines of the American Heart Association/Academy of Pediatrics Neonatal Resuscitation Program.
   2. The CNM will communicate with the on call Pediatrician about any newborn needing additional assistance after delivery and as needed.
   3. Newborn Care: The nurse-midwife may perform and enter the initial physical examination and discharge exam on the newborn record and write admission orders. Complications or abnormalities will be promptly reported to the supervising physician. The supervising physician must countersign medications orders (unless prescribed under the approved medications listed) and will examine infant(s) when requested to do so by CNM or at the physician's discretion.

III **RECORDS:**
Documentation shall be sufficiently complete to include: an appropriate database, differential diagnosis, management plans and final disposition of the patient. Information shall be recorded on the patient record, which is centrally filed and available to all care providers.

IV **FORMULARY OF APPROVED MEDICATIONS:**
The following medications may be prescribed by the CNM without the need for physician co-signing; the CNM may prescribe other medications with the appropriate consultation and according to state licensure guidelines but these medications must be countersigned by the physician.

A. Ordering other medications for use in the antepartum, intrapartum and postpartum periods;

- Any medication the patient is on before admission to the hospital
- Acetaminophen 650mg-1000mg q 6 hours prn headache, fever, pain
- Ambien 5-10 mg PO q hs for sleep
- Aspirin 81mg q day for preeclampsia prevention.
- Benadryl 25-50mg PO/IV prn sleep, allergic reaction
- Benzocaine-menthol anesthetic spray
- Caboprost Tromethamine, (Hemabate) 250 mcg. IM or IU to uterine atony/bleeding after delivery
- Celexa (citalopram) 10-40mg q day for depression/anxiety
- Docusate Sodium 250 mg at HS for use as stool softener after delivery

- Fentanyl 50-100mcg IVP as needed for pain analgesia
- Ferrous Sulfate 325mg PO Q day or twice daily
- Flu vaccine
- Hydralazine- 5mg IV. May repeat 5-10mg in 20 minutes to max of 20-30mg in 24 hours. Use for immediate treatment of hypertension until consultation obtained
- Hydrocodone/acetaminophen (Norco) 5/325mg tabs, 10/325mg tabs- 1 tab q 4-6 hours prn pain
- Ibuprofen 600mg q 6 hours prn
- Indomethacin- for women 24-32 weeks pregnant- 50-100mg loading dose then 25mg q 4-6 hours prn contractions/management preterm labor
- Initiate Magnesium protocol for emergency situations
- IV fluids: LR, D5LR, NS, D5W, D5 ½ NS for hydration and for administration of medications
- Labetalol IV- 20-80mg q 10minutes prn. Hypertensive crisis dosing: 20mg=>40mg=>80mg=>80mg=>80mg for immediate management of hypertension until consultation obtained
- Labetalol PO- 100-400mg BID-TID
- Lanolin breast ointment
- Lexapro (escitalopram) 10-20mg q day for depression/anxiety
- Lidocaine 1% for local anesthesia
- Medroxyprogesterone acetate 150 mg IM postpartum method of birth control
- Metformin 500-1000 mg extended release or immediate release PO
- Methergine 0.2 mg IM or IV for treatment of uterine atony after delivery
- Methergine 0.2 mg IM post-delivery for treatment of uterine atony after delivery
- Methergine 0.2 mg PO q 8 hours for treatment/prevention of uterine atony after delivery
- Misoprostol- ~~400mcg~~ 600mcg sublingual or 800-1000mcg per rectum for postpartum hemorrhage.
- Misoprostol- 25mcg per vagina q 3-4 hours prn for labor induction
- MMR vaccine- 0.5mL subcutaneous
- Morphine Sulfate 2 mg IV every 15 minutes PRN
- Motrin 600 mg, PO Q 6 hours
- Naloxone 0.4 mg for reversal of respiratory depression
- Nexplanon 68mg subdermal implant- placed on L&D for postpartum contraception
- Nifedipine immediate release or extended release- 20-30mg loading dose then 20-30mg q 3-8 hours prn max 180mg/day. Extended release 30mg three times daily prn, max 90mg/day.
- Nitrous Oxide per protocol as needed for pain analgesia
- Nubain ≤ 20 mg sub-q or ≤ 10 mg IV or IM, may repeat X 1
- Ofirmev (acetaminophen) 1 gram IV q 6 hours prn pain
- Oxycodone- 5-10mg q 6 hours prn pain
- Oxytocin 30 units/500mL NS intrapartum for labor induction/augmentation, max 32 milliunits/minute
- Oxytocin 30 units/500ml NS fluid post-delivery for the treatment/prevention of uterine atony.
- Pen G IVPB 5 million units followed by 2.5 million units q 4 hr. for positive b-strep until delivery. (May use Ampicillin If Pen G not available)

- Phenergan ≤50 mg IM ONLY, may repeat X 1
- Pitocin (during co-management with supervising attending) 2mU/min IV, may increase by 2mU/min every 15 min to max of 32 mU
- Pitocin 10-20 mU IM as needed post placenta delivery if needed
- Prilosec (omeprazole) 20-40 mg q day
- Prozac (fluoxetine) 10-80mg q am for depression/anxiety
- Rh immune globulin 300 mcg IM for Rh-negative mothers to prevent sensitization
- Rubella Vaccine: 0.5cc sq for non-immune mothers after delivery
- Saline or Heparin locks to maintain IV access as precaution or for the administration of meds
- Tdap vaccine 0.5mL
- Terbutaline 0.25 mg sub-q for the immediate management of preterm labor until consultation obtained
- Tranexamic Acid- 1000mg IV x1 for postpartum hemorrhage.
- Tums 2 tabs PO prn
- Xanax (alprazolam) 0.25-1mg q 8 hours prn anxiety
- Vistaril ≤ 100 mg IM, may repeat X 1
- Witch Hazel pads
- Zofran 4-8 mg IV/PO q 6 hours prn nausea
- Zoloft (sertraline) 50-200mg PO daily for depression/anxiety

B. Ordering neonatal medications

- Erythromycin ophthalmic ointment for prophylactic eye treatment
- Hepatitis B vaccine – pediatric dose- for infants born of Hb_sAG negative mothers
- Hepatitis B vaccine –pediatric dose- IM for infants born of Hb_sAG positive mothers
- ~~Hydrogen peroxide for routine care of circumcision site~~
  to the guidelines in the AHA/AAP neonatal resuscitation program
- Volume expanders (Whole blood, 5% albumin, Normal saline, LR) 10ml/kg IV for use in resuscitation according to the guidelines in the AHA/AAP neonatal resuscitation program
- Epinephrine 1:10,000 0.1-0.3 ml/kg IV or ET for use in resuscitation, according
- HBIG 0.5cc IM for treatment/prevention of Hepatitis B in newborn
- ~~Naloxone 0.4 or 1.0 mg for the treatment of respiratory depression in the newborn~~
- Phytonadione ~~0.5~~ 1.0 mg IM for prevention of neonatal bleeding disorders

Approval	Date
CCOC	12/15/2016
Peri-Peds	06/30/2020
Pharmacy and Therapeutics	05/14/2020
Interdisciplinary Practice Committee	06/10/2020
MEC	07/07/2020
Board of Directors	
Last Board of Director review	2/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standardized Procedure - Certified Nurse Midwife	
Scope: Perinatal, Surgery	Manual: Perinatal - Standards of Practice Independent/Interdependent
Source: ~~OB Nurse Manager~~Medical Staff Support Manager	Effective Date: 1/18/17

Developed: 3/98
Revised: 3/09, 6/09, 9/16SG, 6/2020 dp
Reviewed: 05/2018
Index Listing: Midwife Policy

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standardized Procedure - Certified Nurse Midwife	
Scope: Perinatal, Surgery	Manual: Perinatal - Standards of Practice Independent/Interdependent
Source: ~~OB Nurse Manager~~Medical Staff Support Manager	Effective Date: 1/18/17

APPENDIX A: CRITERIA FOR CO-MANAGEMENT, COLLABORATION, EXCLUSIONS AND MEDICAL MANAGEMENT.

Criteria for Certified Nurse Midwife delivery will include:

Gestational age > 36 to < 42 weeks
EFW > 2500 - <4000 grams
Normal prenatal care and low risk factors, gestational diabetes diet-controlled

Exclusions – Any patient that does not meet the criteria above will be co-managed with the Attending Physician.

Medical Management of the patient may be transferred to the Physician during the course of the hospitalization by agreement between the CNM and physician.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standardized Procedure - Certified Nurse Midwife	
Scope: Perinatal, Surgery	Manual: Perinatal - Standards of Practice Independent/Interdependent
Source: ~~OB Nurse Manager~~Medical Staff Support Manager	Effective Date: 1/18/17

APPENDIX B: CERTIFIED NURSE MIDWIFE FIRST ASSISTANT (CNMFA)

I. POLICY:

A. The Certified Nurse Midwife First Assistant (CNMFA) assists the attending obstetrician during a Cesarean Section by providing aid in exposure and other technical functions, which will help the surgeon, carry out a safe operation with optimal results for the patient.

B. Only a CNM currently licensed in California, who meets all the criteria specified within this procedure may perform as a CNMFA.

C. The CNMFA may function under this standardized procedure when the attending obstetrician has determined that the CNMFA can provide the type of assistance needed during the specific surgery.

II. PROTOCOL:

A. The CNMFA may assist with the positioning and draping of the patient, or perform these actions independently, if so directed by the physician

B. The CNMFA will provide retraction by:
1) closely observing the operative field at all times
2) managing all instruments in the operative field to prevent obstruction of the surgeon's view
3) anticipating retraction needs with knowledge of the surgeon's preferences and anatomical structures

C. The CNMFA may provide hemostasis by:
1) sponging and utilizing pressure as necessary
2) utilizing suctioning techniques
3) applying clamps on superficial vessels and tying or electro-coagulation of them as directed by the physician

D. The CNMFA may perform knot tying by using basic techniques of knot tying to include two-handed tie, one-handed tie and instrument tie

E. The CNMFA may provide closure of layers by approximating tissue layers under the direct supervision of the physician

F. The CNMFA will assist the physician at the completion of the surgical procedure by:
1) affixing and stabilizing all drains
2) cleaning the wound and applying the dressing

III. QUALIFICATIONS:

A. A CNM who is approved as a CNMFA at NIHD may function as first assistant if all the following conditions exist:
1. currently licensed as a CNM in California

Title: Standardized Procedure - Certified Nurse Midwife	
Scope: Perinatal, Surgery	Manual: Perinatal - Standards of Practice Independent/Interdependent
Source: ~~OB Nurse Manager~~Medical Staff Support Manager	Effective Date: 1/18/17

2. successful completion of a course in CNM First Assisting as noted in the above procedure- refer to section B-5 (a copy of the certificate of completion will be placed in the CNMFA's credentialing file)
3. demonstrated knowledge and skill in applying principles of asepsis and infection control and demonstrated skill in behaviors that are unique to functioning as a CNMFA
4. demonstrated knowledge of surgical anatomy, physiology and operative procedures encountered in a Cesarean delivery
5. demonstrated ability to function effectively and harmoniously as a team member
6. able to perform ~~CPR~~BLS, completion of ACLS preferred
7. able to perform effectively in stressful and emergency situations

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Standardized Procedure - Certified Nurse Midwife	
Scope: Perinatal, Surgery	Manual: Perinatal - Standards of Practice Independent/Interdependent
Source: ~~OB Nurse Manager~~Medical Staff Support Manager	Effective Date: 1/18/17

APPENDIX C: APPROVALS

A. The following CNM's who have been approved to function as Certified Nurse Midwives under this standardized procedure are:

Name:	Approval Date:

B. The following CNM's who have been approved to function as a CNMFA under this standardized procedure are:

Name:	Approval Date:

C. This standardized procedure has been approved for use at Northern Inyo Hospital by:

Chairman, Interdisciplinary Practice Committee	Date
Administrator	Date
Chief of Staff	Date
President, Board of Directors	Date

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedure – General Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

PURPOSE:
To outline the general policy for the development of standardized procedures and the evaluation of those authorized to perform the standardized procedure functions, as promulgated by the guidelines of the Medical Board of California and the Board of Registered Nursing.

DEFINITIONS:

1. **Nurse Practitioner** (ANP, FNP, or PNP) is licensed by the State of California Board of Registered Nursing and possesses additional preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary health care, and who has been prepared in a program that conforms to board standards.

2. **Certified Nurse Midwife** (CNM) encompasses a full range of primary health care services for women from adolescence beyond menopause. These services include primary care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth and the postpartum period, care of the normal newborn during the first 28 days of life, and treatment of male partners for sexually transmitted infections. Midwives provide initial and ongoing comprehensive assessment, diagnosis, and treatment. They conduct physical examinations; prescribe medications; admit, manage and discharge patients; order and interpret laboratory and diagnostic tests and order the use of medical devices. Midwifery care also includes health promotion, disease prevention, and individualized wellness education and counseling.

POLICY:

1. Development and Review of Standardized Procedures
    a. All standardized procedures are developed collaboratively and approved by the Northern Inyo Healthcare District (NIHD) Interdisciplinary Practice Committee (IDPC) and must conform to all ~~11~~ steps of the standardized procedure guidelines as specified in Title 16, CCR Section 1474.
    b. All standardized procedures will be kept in a manual (either hardcopy or electronic) that includes dated and signed approval sheets of the standardized procedures and a list of persons covered by the standardized procedures.
    c. All standardized procedures are to be reviewed ~~every 3 years at minimum~~annually by the NP(s), Medical Director of the setting the NP(s) function(s) in, and ~~then~~ by the IDPC. Standardized procedures will be updated as practice changes.
    d. All changes or additions to the standardized procedures are to be approved by the IDPC. All standardized procedures approved by the IDPC will be sent to the Medical Staff Executive Committee and, if so approved, to the NIHD Board of Directors.
2. Setting of Practice
    a. Northern Inyo Healthcare District (NIHD) and affiliated locations, as appropriate for specialty.
3. Scope of Practice

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a. The NP & CNM may perform the following functions within his/her specialty area and consistent with their experience and credentialing: assessment, management, and treatment of episodic illness, chronic illness, contraception, and the common nursing functions of health promotion, and general evaluation of health status (including but not limited to ordering laboratory procedures, x-rays, and physical therapies as well as recommending diets, and referring to specialty services when indicated).
b. Standardized procedure functions, such as managing medication regimens, are to be performed at the approved setting of practice. The supervising physician, or his/her relief, will be available in person, by electronic means, or by phone. PNP(s) will consult the Pediatrician supervisor on call. CNM(s) will consult OB/GYN Physician on call.
c. Physician consultation is to be obtained under the following circumstances:
    i. Emergent conditions requiring prompt medical intervention after the initial stabilizing care has been started.
    ii. Acute decompensation of patient situation.
    iii. Problem which is not resolving as anticipated.
    iv. History, physical, or lab finding inconsistent with the clinical picture.
    v. Upon request of patient, nurse, or supervising physician.
d. Medical Records: Medical record entries by the NP or CNM shall include, for all problems addressed: the patients' statement of symptoms, the physical findings, results of special studies, the NP's or CNM's assessment and management plan including further studies ordered, medication or procedures, information given patient and the names of any physicians consulted.

4. Qualifications and Evaluations
    a. Each nurse performing standardized procedure functions must have a current California registered nursing license, be a graduate of an approved Nurse Practitioner or Certified Nurse Midwife program, and have current certification as a NP or CNM by the California Board of Registered Nursing.
    b. Evaluation of competence in performance of standardized procedure functions will be done in the following manner:
        i. Initial: ~~at 3 months, 6 months and 12 months by the Supervising Physician, and other physicians and colleagues, and review of charting completed during performance period being evaluated.~~ Within the initial focused professional practice evaluation (FPPE) period the Supervising Physician(s) will evaluate performance via direct observation, consultations and chart review/co-signature and provide feedback to the interim NP or CNM. Input from other physicians and colleagues will be utilized. Recommendations to move from interim status to full status once the FPPE has been satisfactorily completed will be considered. Nurse Manager(s) along with the Medical Director(s) and Supervising Physician(s) will provide feedback utilizing performance evaluation based upon the NP/CNM job description.

ii. Routine: every 6 months thereafter, in accordance with the Medical Staff Ongoing Professional Practice Evaluation (OPPE) policy.
iii. Follow-up: areas requiring increased proficiency, as determined by the initial or routine evaluation, will be reevaluated by the supervising physician at appropriate intervals until acceptable skill level is achieved.

c. Medical Record Review shall consist of audit by the supervising physician(s) of at least 5% of patients seen by the NP or CNM.
d. Further requirements shall be regular continuing education in primary care, including reading of appropriate journals and new text books, attending conferences in primary care sponsored by hospitals, professional societies, and teaching institutions equaling ~~15~~ 50 hours every two years~~a year~~, minimum.
   i. A record of continuing education must be submitted to the Medical Staff Office every other year at re-credentialing.
   ii. Continuing education information will remain on file in the NP/CNM's competency notebook. ~~A copy of the competency assurance documents will be submitted to Human Resources (HR) at the end of each calendar year to be stored in the employee HR file.~~

5. Protocols
   a. The standardized procedure protocols developed for the use by the NP and CNM are designed to describe the steps of medical care for given patient situations. They are to be used in the following circumstances: health promotion exams, contraception, routine gynecological problems, trauma, infectious disease contacts, management of acute/episodic or chronic conditions, and furnishing of medications.

REFERENCES:

1. 16 CCR §1474. Standardized Procedure Guidelines. Retrieved 16 Apr 2018.

Approval	Date
Interdisciplinary Practice Committee	06/10/2020
Medical Executive Committee	07/01/2020
Board of Directors	
Last Board of Directors Review	02/20/2019

Developed:
Reviewed: 5/2018 dp
Revised: 5/2018 dp, 12/2018 dp, 6/2020 dp
Supersedes: *General Policy for the Rural Health Clinic Nurse Practitioner or Certified Nurse Midwife*
Index Listings:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedure – General Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedure – General Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

APPROVALS

Chairman, Interdisciplinary Practice Committee	Date
Administrator	Date
Chief of Staff	Date
President, Board of Directors	Date

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedure – General Policy for the Nurse Practitioner or Certified Nurse Midwife	
Scope: Nurse Practitioner, Certified Nurse Midwife	Manual: Medical Staff
Source: Medical Staff Support Manager	Effective Date: 6/20/18

ATTACHMENT 1 – LIST OF AUTHORIZED NP's or CNM's

1. _____ NAME _____ DATE
2. _____ NAME _____ DATE
3. _____ NAME _____ DATE
4. _____ NAME _____ DATE
5. _____ NAME _____ DATE
6. _____ NAME _____ DATE
7. _____ NAME _____ DATE
8. _____ NAME _____ DATE
9. _____ NAME _____ DATE
10. _____ NAME _____ DATE

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Utilization Review Plan	
Scope: Hospital Wide	Manual:
Source: CNO	Effective Date: 7/1/15

PURPOSE:
The purpose of this plan is to identify the elements of a comprehensive utilization review (UR) management plan, which is necessary to satisfy Medicare Conditions of Participation. This plan is coordinated to support Northern Inyo Healthcare District (NIHD) mission and vision by collecting and reviewing data that assures the appropriate allocation of hospital resources and specifically monitoring the necessity for appropriateness of hospitalization extended length of stay and the quality of this interaction. This plan provides framework for addressing under and over utilization of resources as well as the review of treatment to determine that the care provided meets professionally recognized standards of care.

POLICY:
1. Northern Inyo Healthcare District's (NIHD's) UR plan applies to all admitted patients (inpatients, observations & swing patients) regardless of payment source and all admissions are reviewed in accordance with federal and state regulations governing utilization review.
2. Findings and recommendations of the Utilization Review Committee are reported to the Medical Executive Committee. Additional issues may be referred to Billing and Coding Compliance Committee as needed.
3. The UR plan shall be reviewed by the Utilization Review Committee and the Medical Executive Committee at least once a year and revised as needed.

DEFINITIONS:
1. **Utilization Management Plan** is the organizational plan that contains the essential requirements for the establishment and implementation of a utilization management process to ensure the quality, appropriateness and efficiency of care and resources furnished by the facility and medical staff. The purpose of this plan is to ensure that patients at Northern Inyo Hospital receive medically necessary and appropriate care at the appropriate time and in the appropriate setting.
2. **InterQual Criteria** are clinical decision support guidelines licensed for use by hospitals to evaluate the appropriateness of medical interventions and level of care based on clinical criteria and standards.
3. **Secondary Review** is a clinical review performed by a provider member of the Utilization Review Committee or a Provider Advisor when InterQual guidelines suggest a different patient status or level of care than that ordered by the patient's provider and/or a potential quality concern.

PROCEDURE:
Overview:
1. A developed plan that contains a delineation of responsibilities and authority of personnel for conducting internal utilization review.
2. Establishes procedures to review the medical necessity of admissions, extended stays, and professional services, and appropriateness of settings.

3. Establish procedures for coverage determinations, denials, appeals, and peer review within the organization.
4. Establishes reporting, corrective action and documentation requirements for the utilization management process.

Plan Requirements:

1. Commitment and cooperation from the hospital administration and Medical/Hospital staff.
2. Objective Review Criteria
3. Maintenance of appropriate data
4. Integration of UR findings into quality improvement activities
5. Patient record access appropriate for Utilization review

Composition: – See ***Medical Staff bylaws***

1. The Utilization Review committee is a standing committee of the medical staff and is responsible to the Medical Staff Executive Committee. The UR Chair or designee will lead this committee. The committee shall be comprised of one additional provider and other practitioners to perform the utilization management function. The other members may be any of the other types of practitioners specified in 482.12(c) (1). The Utilization Review and Medical Records Committee shall consist of at least 4 active district staff members selected on a basis that will ensure insofar as feasible, representation of the services and the major clinical specialties which are routinely practiced by Practitioners at Northern Inyo Hospital. These may include a member of the Quality Improvement Council, the Chief Nursing Officer, Billing Department Manager, Manager Charge Capture and HIMS Services, Case Manager, Medical Staff Coordinator, Chief Medical Officer and Chief Financial Officer.
2. The UR committee may be supported by representatives from Case Management and Administration, but only providers and other practitioners are members for regulatory purposes.
3. No person with a direct financial interest may participate in reviews conducted by the Committee.

Meetings:

1. The UR committee shall meet as a separate and distinct committee with its own agenda and minutes. The committee shall meet as often as necessary to accomplish primary functions, but no fewer that quarterly.
2. Committee minutes shall be maintained according to hospital policy and include the date/time of the meeting, attendees, standard reports, action item follow-up, focused reviews, audits, and action to be taken. The minutes shall exclude patient or provider names from charts reviews.

Standard Reports:

1. Length of Stay

2. Avoidable Day
3. Appeal Outcomes
4. Denials
5. Readmission Review

Critical Indicators for Peer Review:

1. Will be developed by the UR Committee and updated annually.
2. Approved at the Medical Executive Committee and Board of Directors annually.
3. Include the follow items:
   a. InterQual review results-Cases that do not satisfy criteria for admission, continued stay and/or level care
   b. Condition Code 44
   c. Incorrect Status
   d. Inadequate Documentation

Authority and Responsibility:

UR (Case Management) Committee Chair

1. Assigns responsibility for medical necessity secondary review process
2. Evaluates the effectiveness of utilization management activities
3. Reports evaluation results and/or issues to appropriate committees.

Utilization Review Committee shall perform the following functions:

1. Delineate the scope of utilization review provided within the hospital
2. Develop critical indicators to be used as screening devices in reviewing the utilization of Hospital Services.
3. Establish thresholds used to trigger provider review.
4. After cases have been isolated using the critical indicators, evaluate the quality and appropriateness of care administered and identify areas for improvement.
5. Review patient care services to ascertain if quality care within the standards of the Hospital and Medical Staff is being provided in the most cost-effective manner, address inappropriate utilization of care and resources.

Chief Nursing Officer under the direction of the Utilization Review Committee, has responsibility for the following activities:

1. Delegates responsibilities to appropriate personnel to ensure coverage for determining appropriate patient status.
2. Provides guidance to the medical staff and hospital personnel regarding medical necessity criteria and appropriate service determinations
3. The process of measuring and assessing the use of professional care, services, procedures, and facilities, including the medical necessity and appropriateness of:
   a. Admission
   b. Level of care
   c. Appropriate utilization of resources

d. Continued stay
e. Discharge/post hospital referrals
f. Readmissions
g. Performance improvement team activities to improve systems and processes associated with inefficient or inappropriate delivery of care and services.

Case Manager (CM):

1. Reviews medical record documentation to obtain information necessary for UR determinations.
2. Screens patients from time of admission for potential discharge and aftercare needs.
3. Applies UR criteria objectively regarding level of care using InterQual guidelines on all admissions and continued stays regardless of payer.
4. Reviews all continued stays and addresses all concerns with attending provider/hospitalist.
5. If admission criteria are not satisfied, the reviewer shall contact the attending provider for additional information. If additional information is provided to support the admission, ~~satisfy admission criteria~~, the admission shall be approved.
    a. If additional information is not provided or the case still fails to satisfy admission criteria, an alternate level of care (LOC) shall be discussed with the attending provider. If the attending provider agrees that an alternate LOC is appropriate, the CM shall facilitate the transfer. If the attending does not agree to transfer to an alternate LOC, the case shall be referred for secondary review.

Secondary Review Process

1. When an admission or continued stay case is referred by the Case Manager to a ~~member~~ medical provider who is a member of the UR committee for secondary review, the reviewer shall review the case based on the documentation in the medical record and discussions with the attending provider in order to determine medical judgment. Secondary review determinations shall be documented and supported with clinical rationale.
2. If the ~~provider member~~ medical provider of the UR committee determines that an admission or a continued stay is not medically necessary, the Case Manager will be contacted and provided instructions on the appropriate level of care. Any determination to transfer a patient from the inpatient level of care to the observation level of care resulting from the secondary review process must involve a provider of the UR committee and must also comply with the requirements of Condition Code 44.
3. If the UR committee or designee decides that continued stay in the hospital is not medically necessary, the designee must give written notification to the hospital, the patient, and the practitioner responsible for the care no later than two (2) days after the determination. (*See Utilization Review Plan**)

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Utilization Review Plan	
Scope: Hospital Wide	Manual:
Source: CNO	Effective Date: 7/1/15

REFERENCES:

1. A-0308
    a. **§482.30 Condition of Participation: Utilization Review**
2. A-309
    a. **§482.30(a) Standard: Applicability**
3. A-0310
    a. **§482.30(b) Standard: Composition of Utilization Review Committee**
4. A-0311
    a. **§482.30(c) Standard: Scope and Frequency of Review**
5. A-3012
    a. **§482.30(d) Standard: Determination Regarding Admissions or Continued Stays**
6. A-0313
    a. **§482.30(e) Standard: Extended Stay Review**
7. A-0314
    a. **§482.30(f) Standard: Review of Professional Services**
8. TENET Utilization Management Plan

CROSS REFERENCE P&P:

1. Utilization Review Plan*
2. Discharge Planning

Approval	**Date**
CCOC	4/20/2020
UR Committee	6/25/2020
MEC	7/7/2020
Board of Directors	1/24/18
Last Board of Director review	

Developed: 2/15
Reviewed: 12/1/2017
Revised: 11/2016, 12/2016, 4/2020ta

CALL TO ORDER

The meeting was called to order at 5:30 pm by Jean Turner, District Board Chair.

PRESENT

Jean Turner, Chair
Robert Sharp, Vice Chair
Jody Veenker, Secretary
Mary Mae Kilpatrick, Treasurer
Topah Spoonhunter, Member-At-Large
Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer
Tracy Aspel RN, BSN, Chief Nursing Officer
Will Timbers MD, Interim Chief Medical Officer
Stacey Brown MD, Chief of Staff (via online conference)
Vinay Behl, Interim Chief Financial Officer (via online conference)
Keith Collins, District Legal Counsel

OPPORTUNITY FOR PUBLIC COMMENT

Ms. Turner announced at this time persons in the audience may speak on any items not on the agenda on any matter within the jurisdiction of the District Board. Members of the audience will have an opportunity to address the Board on every item on the agenda, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on the agenda for the meeting. Public comments were heard from the following:

- Michelle Scott
- Kaylyn Rickford
- Samantha Bumgarner
- Heleen Welvaart
- Eva Judson

REQUEST FOR PROPOSALS FOR AUDIT SERVICES

Interim Chief Financial Officer Vinay Behl reported the District is in process of renegotiating various contracts, including the contract for audit services. Mr. Behl provided an overview of the projected costs of services from the following submitted proposals:

- Eide Bailly
- BKD
- Wipfli
- MossAdams

It was moved by Topah Spoonhunter, seconded by Robert Sharp, and unanimously passed to approve the selection of Eide Bailly for the provision of audit services to the District.

REQUEST FOR PERMANENT CHIEF MEDICAL OFFICER POSITION AT NIHD

Interim Chief Executive Officer Kelli Davis called to attention a request for a permanent Chief Medical Officer (CMO) for the District. The CMO would be an integral part of the executive team and would form a strong conduit between administration and the medical staff. Dr. Brown, Chief of Staff, reported that the medical staff is supportive of the CMO role.

	Concerns from board members were heard regarding the financial impact of a permanent CMO position. It was moved by Robert Sharp, seconded by Mary Mae Kilpatrick and unanimously passed to table this item for addition to the next Special Board Meeting agenda at which time the 2020-2021 budget will be presented.
TUITION REIMBURSEMENT POLICY AND PROCEDURE	Chief Nursing Officer Tracy Aspel called to attention an update to the *Tuition Reimbursement* policy and procedure which would allow benefitted employees (full-time and part-time) of the District to apply for tuition reimbursement. It was moved by Mary Mae Kilpatrick, seconded by Jody Veenker, and unanimously passed to approve the policy for approval as presented.
AED (AUTOMATED EXTERNAL DEFIBRILLATOR) PURCHASE	Tracy Aspel presented to the Board of Directors a request for the purchase of two Automated External Defibrillators (AEDs) for the Joseph House and the Birch Street Annex District properties. It was recommended that the request for purchase of the AEDs be presented to the NIHD Foundation Board and the Auxiliary for possible funding. It was moved by Robert Sharp, seconded by Jody Veenker, and unanimously passed to table this item.
RETURN ON INVESTMENT ANALYSIS COMMITTEE UPDATE	Vinay Behl presented to the Board a summary sheet of the clinical and administrative service lines and contracts that are currently under review by the Return on Investment Analysis Committee for their cost to the district, as well as the proposed action plans to address the listed items. Tracy Aspel reported that the committee determined the NEST program will be discontinued due to its annual loss of $250,000. Moving forward, the community can expect to receive these newborn support services from the District's pediatric providers in the outpatient clinic setting. Comments from the audience were heard regarding the closing of the NEST program.
BOARD AGENDA ITEM REVIEW AND APPROVAL PROCESS	Ms. Davis called to attention the proposal for the Board agenda item review and approval process and policy. It was moved by Jody Veenker, seconded by Topah Spoonhunter, and unanimously passed to approve the policy and forms as presented.
CEO SIGNATURE AUTHORITY	Ms. Davis reported that she and the Compliance Office are reviewing past meeting minutes from the Board of Directors to determine whether the CEO had been previously granted signature authority on behalf of the Board. More information will be presented after further review.
REQUEST FOR SPECIAL BOARD MEETING	Ms. Davis proposed the scheduling of a Special Board meeting for the review of the District operating and capital budget for 2020-2021. Mary Mae Kilpatrick further requested that the budget review include information pertaining to expenditures made by the Board of Directors. It

was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve the scheduling of a Special Board meeting on Wednesday, June 24, 2020 at 5:30pm.

SOUTHERN INYO HEALTHCARE DISTRICT AND NORTHERN INYO HEALTHCARE DISTRICT PEDIATRICS AND ORTHOPEDIC SERVICE AGREEMENT

Ms. Davis called to attention the agreement between Southern Inyo Healthcare District (SIHD) and Northern Inyo Healthcare District for the provision of pediatric and orthopedic services signed on February 11, 2020 by former NIHD CEO Kevin S. Flanigan, MD and SIHD CEO Peter Spiers. It was reported that there are some concerns in the District's capacity to provide these services on a regular basis.

PEPRA PLAN – REQUEST FOR REFUND OF PLAN CONTRIBUTIONS TO KEVIN FLANIGAN, MD AND DISCUSSION OF FUTURE OF PEPRA PLAN

It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve the addition of this agenda item as it was found that there was a need to take immediate action on this item and the need arose after the posting of the Board agenda.

Ms. Davis reported that former CEO Kevin S. Flanigan, MD submitted a request for a refund of his PEPRA plan contributions in the total of $57,000. Comments from Dr. Kevin Flanigan were heard. It was moved by Ms. Kilpatrick, seconded by Mr. Sharp, and unanimously passed to approve the request for refund of plan contributions.

Additionally, it was recommended by the Board that the CEO Search Committee investigate whether the continuation of a PEPRA plan is considered best practice for the future recruitment of a CEO.

REPORTS

The following reports were presented:

BUILDING SEPARATION CONSTRUCTION PROJECT UPDATE

Luis with Columbo Construction reported that all demolition has been completed with the building separation and they are now in the reconstruction process. It is anticipated that the District's milestone will be met on time to keep the District in compliance with its plan.

GOVERNANCE CONSULTANT UPDATE

Ms. Turner reported the Board is moving forward with scheduling a meeting with Dr. Rice. Board members discussed the preferred venue of the meeting.

CHIEF EXECUTIVE OFFICER SEARCH UPDATE

Ms. Veenker reported on the search committee's initial meeting, in which the committee determined the following:

- A survey for community and staff engagement will be drafted and distributed.
- The District will post the position on its website in addition to opening a search with the executive search firm WittKieffer. Applications submitted directly to the District will be also vetted by WittKieffer's process in order to maintain consistency. It was recommended that the search committee discuss pricing options

with WittKieffer in the event that the selected candidate was recruited through the District's internal means.

CHIEF OF STAFF REPORT

Chief of Staff Stacey Brown, MD presented to the Board of Directors the Medical Staff Officers and Service Chiefs for the 2020-2021 Medical Staff year, which are as follows:

- Chief of Staff: Stacey Brown, MD
- Vice Chief of Staff: Charlotte Helvie, MD
- Immediate Past Chief of Staff: William Timbers, MD
- Chief of Emergency Room Service: Sierra Bourne, MD
- Chief of Medicine/Intensive Care Service: Nickoline Hathaway, MD
- Chief of Obstetrics: Martha Kim, MD
- Chief of Pediatrics: Charlotte Helvie, MD
- Chief of Radiology: Edmund Pillsbury, MD
- Chief of Surgery: Robbin Cromer-Tyler, MD
- Member-at-Large: Anne Wakamiya, MD

Dr. Brown additionally reported the Medical Executive Committee recommends approval of the following Medical Staff appointments:

1. Gregory Gaskin, MD (emergency medicine) – provisional active staff
2. Timothy Brieske, MD (family medicine) – provisional active staff

It was moved by Robert Sharp, seconded by Jody Veenker, and unanimously passed to approve all Medical Staff appointments as requested.

Dr. Brown reported as per the approved Telemedicine Physician Credentialing and Privileging Agreement, and as outlined by 42CFR 482.22, the Medical Staff has chosen to recommend the following practitioners for Telemedicine privileges relying upon Adventist Health's credentialing and privileging decisions:

1. Armand Rostamian, MD (cardiology) – telemedicine staff
2. Diana Havill, MD (psychiatry) – telemedicine staff

It was moved by Jody Veenker, seconded by Robert Sharp, and unanimously passed to approve all telemedicine staff appointments as requested.

Dr. Brown also stated the Medical Executive Committee recommends approval of the following Staff Category Change after careful review and consideration:

1. Ruhong Ma, DO (internal medicine) – change from locums to provisional active staff. Privileges valid through 12/31/2021.

It was moved by Mary Mae Kilpatrick, seconded by Jody Veenker, and unanimously passed to approve the staff category change as presented.

Dr. Brown additionally reported the Medical Executive Committee recommends approval of the following Medical Staff resignation:

1. Peter Bloomfield, MD (emergency medicine) – active staff – effective 5/26/2020

It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve the resignation of Dr. Bloomfield.

Dr. Brown reported following careful review, consideration, and approval by the appropriate Committees, the Medical Executive Committee recommends approval of the following District-wide Policies and Procedures:

1. *Pharmacy Downtime Procedure*
2. *Opioid Sedation Scale*
3. *Opioid Administration*
4. *Pain Assessment and Documentation*
5. *Scope of Service Acute/Subacute*
6. *Telemetry Criteria Guideline*
7. *MRI Safety*
8. *Code Blue Procedure – Code Blue Team*
9. *Cardiac Stress Test Protocol and Procedure*

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve all District-wide Policies and Procedures as presented with the exception of the *Telemetry Criteria Guideline,* which was not included in the Board agenda packet for review.

Dr. Brown additionally presented the annual approval of the Radiology Critical Indicators for 2020 by the Radiology department. It was moved by Mr. Sharp, seconded Ms. Kilpatrick, and unanimously passed to approve the critical indicators as presented.

Lastly, Dr. Brown called to attention the changes made to the Internal Medicine core privilege form approved by the Medical Executive Committee. It was moved by Mr. Sharp, seconded by Ms. Kilpatrick, and unanimously passed to approve the revised Internal Medicine core privilege form as presented.

CONSENT AGENDA

Ms. Turner called attention to the Consent Agenda for this meeting, which contained the following items:

1. Approval of minutes of the May 20, 2020 regular meeting
2. Approval of minutes of the May 28, 2020 special meeting
3. Compliance Department quarterly report
4. Policy and Procedure Annual Approvals

It was moved by Mr. Sharp, seconded by Ms. Veenker, and unanimously passed to approve Consent Agenda Items 1-3 as presented and to table the Policy and Procedure Annual Approvals (Item 4).

BOARD MEMBER REPORTS

Ms. Turner then asked if any members of the Board of Directors wished to report on any items of interest. Comments were heard from:

- Vice Chair Robert Sharp, thanking everyone for their service during COVID-19 and reminding all listeners that free COVID-19 testing is now available through Project Baseline.
- Secretary Jody Veenker, congratulating the Owens Valley Career Development Center for obtaining a grant for resiliency training and support services for individuals who have had adverse childhood experiences.
- Member-at-Large Topah Spoonhunter, thanking all staff and expressing how he looks forward to the Executive Search Committee work.

ADJOURNMENT TO CLOSED SESSION

At 7:53 pm Ms. Turner announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Conference with Legal Counsel, anticipated litigation, significant exposure to litigation (*pursuant to Government Code Section 54956.9(d)(2)*), 2 cases.
B. Public Employee Performance Evaluation (*pursuant to Government Code Section 54957(b)*), title: Interim Chief Executive Officer.
C. Conference with Legal Counsel, anticipated litigation, significant exposure to litigation (*pursuant to Government Code Section 54956.9(d)(2)*), Potential privacy breach, Jody DeSousa.

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 8:55 pm the meeting returned to Open Session. Ms. Turner reported the Board took no reportable action.

ADJOURNMENT

The meeting was adjourned at 8:55 pm.

_____
Jean Turner, Chair

Attest: _____
Jody Veenker, Secretary

CALL TO ORDER

The meeting was called to order at 5:30 pm by Jean Turner, District Board Chair.

PRESENT

Jean Turner, Chair
Robert Sharp, Vice Chair
Jody Veenker, Secretary
Mary Mae Kilpatrick, Treasurer
Topah Spoonhunter, Member-At-Large
Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer
Tracy Aspel RN, BSN, Chief Nursing Officer
Will Timbers MD, Interim Chief Medical Officer
Vinay Behl, Interim Chief Financial Officer (via online conference)
Keith Collins, District Legal Counsel

OPPORTUNITY FOR PUBLIC COMMENT

Ms. Turner announced at this time persons in the audience may speak on only items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on this Notice. No public comments were heard.

REVIEW AND APPROVAL OF OPERATIONS AND CAPITAL BUDGET FOR 2020-2021

Interim Chief Financial Officer Vinay Behl presented an overview of the budget preparation process for the 2020-2021 fiscal year, which included the following:

- Review of the 2019-2020 revenues by service department, and the projected revenues for 2020-2021, with estimated volumes being less than current.
- Review of revenue by insurance payers for 2019-2020, and the 2020-2021 projection of reduced expected payments.
- Review of income statements for the previous, current and next fiscal years.
- Review of the planned capital budget expenditures.

Mr. Behl reported the current 2019-2020 fiscal year is estimated to close at $4.2 million in net losses, without accounting for the funding received from COVID-19 relief grants. The 2020-2021 fiscal year is projected to have higher costs and less revenue, resulting in a $10 million deficit.

Mr. Behl discussed the mitigation plan that is being implemented by the executive team to address these budget projections, including assessing existing services for cost-savings, considering new services that may increase revenue, investigating bond refunding, and applying for additional provider relief grants. Mr. Behl expressed his support of the existing executive leadership’s ability to implement these measures.

Additionally, Mr. Behl recommended the Board of Directors consider postponing the search for a new Chief Executive Officer for twelve

months, which would result in significant cost-savings to the District in salaries and benefits alone.

Comments in support of Kelli Davis' continuance in the Interim Chief Executive Officer role were heard from Interim Chief Medical Officer, Dr. Timbers, and Chief Nursing Officer Tracy Aspel.

It was recommended by the Board of Directors that leadership reach out to the executive search firm, WittKieffer, to cancel the search for a Chief Executive Officer. The Board expressed their appreciation of staff's hard work in the budget process and reported they would re-evaluate the status of the Interim Chief Executive Officer and Interim Chief Medical Officer positions in six months.

Genifer Owens additionally reported that the Board spend for 2019-2020 was $42,000 for stipends, travel, and conferences. Travel is cancelled for the next fiscal year for all of the District, which will result in cost-savings.

Lastly, Mr. Behl provided clarification that the defined benefit plan market is very volatile at the moment, and the suspension of the District's contribution to the plan is only temporary. The costs associated with contributing to this plan are budgeted for next fiscal year and will continue to accrue while the District temporarily suspends payment.

It was moved by Jody Veenker, seconded by Topah Spoonhunter, and unanimously passed to approve the 2020-2021 operations and capital budgets for approval as presented.

ENGAGEMENT OF HG WILSON MUNICIPAL FINANCE, INC., FINANCIAL ADVISOR, FOR REVIEW AND CONSIDERATION FOR REFINANCING 2010 BONDS

Mr. Behl presented a request to approve the appointment of financial advisors and to approve a 10-year extension to the term of the 2010 bonds. The proposed financing scheduled was reviewed, and a timeline was presented with the goal of closing the refinancing process by September 1, 2020.

It was moved by Robert Sharp, seconded by Jody Veenker, and unanimously passed to approve the engagement of HG Wilson Municipal Finance, Inc. as financial advisor in refinancing the 2010 bonds.

REQUEST FOR PERMANENT CHIEF MEDICAL OFFICER POSITION AT NIHD

Interim Chief Executive Officer Kelli Davis presented a request to the Board of Directors for the approval of a permanent Chief Medical Officer position. It was reported that Dr. Timbers would be willing to serve in the role of Interim for an additional twelve months.

It was moved by Robert Sharp, seconded by Jody Veenker, and unanimously passed to approve the approval of a permanent Chief Medical Officer position for the District. The Board recommended reviewing the status of the Interim role in six months, and acknowledged that the existing job description may need to be amended in the future as

the major areas of value are identified.

ADJOURNMENT TO CLOSED SESSION

At 6:55 pm Ms. Turner announced the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Conference with Legal Counsel, anticipated litigation, significant exposure to litigation (*pursuant to Government Code Section 54956.9(d)(2)*), 1 case.
B. Conference with Labor Negotiation, Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*)

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 9:10 pm the meeting returned to Open Session. Ms. Turner reported the Board took no reportable action.

ADJOURNMENT

The meeting was adjourned at 9:10 pm.

_____
Jean Turner, Chair

Attest: _____
Jody Veenker, Secretary

NOTICE
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS SPECIAL MEETING
June 26, 2020 at 2:00 p.m.
2957 Birch Street, Bishop, CA

1. Call to Order at 2:00 pm.
2. ***In Attendance***: Jean Turner, Mary May Kilpatrick, Robert Sharp, Jody Veenker, Topah Spoonhunter, Kelli Davis, Tracy Aspel, Dr. Will Timbers, M.C. Hubbard
   Attendance through Zoom: Dr. Charlotte Helvie, Colleen McEvoy, Sandy Blumberg, Cori Stearns
3. ***Public Comment***: No Public Comments.
4. Governance Training for Northern Inyo Healthcare District Board, was presented via Zoom by Jim Rice with Gallagher Associates.
   - Jim presented and reviewed the BOD's Self-Assessment results
5. Adjournment: 5:00pm

NOTICE
NORTHERN INYO HEALTHCARE DISTRICT
BOARD OF DIRECTORS SPECIAL MEETING
June 27, 2020 at 8:30 a.m.
2957 Birch Street, Bishop, CA

1. Call to Order at 8:30am.
2. ***In Attendance:*** Jean Turner, Mary May Kilpatrick, Robert Sharp, Jody Veenker, Topah Spoonhunter, Kelli Davis, Tracy Aspel, Dr. Will Timbers, M.C. Hubbard
   Attendance through Zoom: Dr. Charlotte Helvie, Barbara Laughon
3. ***Public Comment***: A comment was received from Dr. Helvie regarding physician and Board of Directors collaboration.
4. Part 2 of the Governance Training for Northern Inyo Healthcare District Board was presented by Jim Rice with Gallagher Associates. Discussion included:
   - Position Description – Board Member Election
   - Physician Collaboration
   - Bylaws Review
   - Community Relations
   - Board profiles, Board Education and Role Descriptions
   - Board Orientation, Introductions, Structured On-Boarding, ITS Orientation/Set-Up.Review
   - Governance Website
5. Adjournment: 11:00am

CALL TO ORDER

The meeting was called to order at 5:30 pm by Jean Turner, District Board Chair.

PRESENT

Jean Turner, Chair
Robert Sharp, Vice Chair
Jody Veenker, Secretary
Mary Mae Kilpatrick, Treasurer
Topah Spoonhunter, Member-At-Large
Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer
Tracy Aspel RN, BSN, Chief Nursing Officer
Keith Collins, District Legal Counsel

Ms. Turner announced at this time persons in the audience may speak on only items listed on the Notice for this meeting, and speakers will be limited to a maximum of three minutes each. The Board is prohibited from generally discussing or taking action on items not included on this Notice.

1. Zoom Participant, Tracy: In response to requests for compensation, are Fair Market Value studies public record? Keith believes this information is clearly public record.

PUBLIC RECORDS PRESENTATION, KEITH COLLINS

General Counsel, Northern Inyo Healthcare District, Keith Collins presented information on Public Records, which included the following:

- Introduction to CPRA – California Public Records Act. Enacted in 1968, discussed the history of the act.
- CPRA Government Code 6250. A balance between right to privacy and the right to know.
- Discussed the 2 different rights of access; right to inspect, right to copy
- Discussed equal access to Government records
- Definitions were given for:
  1. Public Records
  2. Writing
  3. Relating to the Conduct of Public Business
  4. Prepared, Owned, Used or Retained
  5. Specifically Identified Records
  6. Person
  7. Member of the Public
  8. Local Agency
- Reviewed 8 areas of Agency Obligations
- Discussed Types of Requests, Right to Inspect Records, Right to Copy Public Records, Form of the Request, Purpose of Request Irrelevant, Procedures/Guidelines, Timing of the Response,

Response Time Frame (Time Extension), Timing of Disclosure, Agency Obligations, Disclosing Electronic Records, Affidavits, Agency Obligations, Inspection Fees, Grounds for Withholding Records (Section 6254 contains a complete list)

- In-depth discussion on Exempted Records, Section 6254 & 6255
- Discussion on Enforcement

ADJOURNMENT: The meeting was adjourned at 7:43pm

_____
Jean Turner, Chair

Attest: _____
Jody Veenker, Secretary

NORTHERN INYO HEALTHCARE DISTRICT

Improving our communities, one life at a time.
One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop, California 93514
(760) 873-5811

DATE: July 15, 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Kelli Davis, Interim CEO

RE: Bi-Monthly CEO Report to the NIHD Board of Director's

REPORT DETAIL

Re-Alignment of Reporting Structure

As Dr. Timbers and I settle into the Interim CMO and Interim CEO roles for up to one year, re-alignment of reporting structure has begun to ensure appropriate support for all District departments fall under the CEO, CMO or CNO. Discussion is ongoing and the re-alignment will be complete and rolled out by July 19. This date allows HR to move the areas effective with a new pay-period.

District Office Relocation

Relocation of Medical Records, Credit & Collection, Payroll, and the Revenue Cycle Director offices have been completed. The plan to have all of the finance related offices centrally located in the Administration Building has been in the works for quite some time. The biggest challenges have been primarily one move must occur prior to another move being able to be done. Coding and Billing will be the next moves to take place in the coming weeks. Signage and media alerts are underway to notify and guide customers and others.

Hospital Council of Northern & Central California

"The Hospital Council of Northern and Central California is the unified voice of our members, acting as a catalyst to empower hospitals to act together on issues affecting patient care and the health status of communities. We are dedicated to advocating to our member hospitals at a local and regional level and in support of California Hospital Association (CHA) at the State and Federal level" (hospitalcouncil.org).
Recently, I had an opportunity to receive an orientation with the Hospital Council representative, David Bacci, who oversees the Eastern Sierra sections. Helpful information and insight in the

opportunities the Hospital Council provides for the pursuit of healthcare specific forums, goals and efforts to the members. Please see the attached documents provided by David Bacci:
2020 HC Kern-Eastern Sierra CEO Section Roster;
California Association Structure; and
California's Hospitals "Did You Know"

CEO Search Committee

The wrap-up meeting for the NIHD CEO Search Committee was held on June 30. This committee has been placed on "hold" due to the Interim CEO role being extended for up to a year by the Board at the June 17, 2020, regularly scheduled meeting. Appreciation was voiced to the participants for the active roles they had held on the committee.
Wittkieffer representative, Mark Andrews, was notified on June 26, 2020, of the decision by the NIHD Board of Director's to suspend the CEO search.

"Inclusive, Engaged and Empathetic"

Through training, education, awareness and example, the District continues to focus on the provision of a safe, respectful and peaceful work and service environment for all team members, patients and visitors. We believe there is a common unity for all team members to share in, support and improve upon the foundation in place at the District.
"NIHD leaders are committed to the sustainable efforts our society must have to address racism, discrimination and basic human rights. We hold on another accountable in our commitment to the provision of a safe and welcoming environment for all team members, patients, visitors and other".
We will continue to look for every opportunity, with regard to inclusivity and equity, to gain insight, celebrate successes and work to improve any areas in need that are identified by team members.

Department Reports

Attached you will find the individual department reports by our leaders who are supported by the CEO. We believe these reports will provide a look into some of the many projects and day-to-day operations taking place at the District.

Closing

The support and guidance by the NIHD Board of Director's is greatly appreciated. As always, please do not hesitate to contact me with any questions or to share any concerns you may have.

Hospital Council
Northern & Central California

2020 HC KERN-EASTERN SIERRA CEO SECTION ROSTER

Member
Sharlet Briggs, PhD
President
Adventist Health Bakersfield, Bakersfield

Member
Martha Samora, RN, CPHQ, FACHE, BSN, MBA
Chief Executive Officer
Encompass Health Rehabilitation Hospital of Bakersfield, Bakersfield

Member
Jeffrey Lingerfelt
President
Adventist Health Tehachapi Valley, Tehachapi

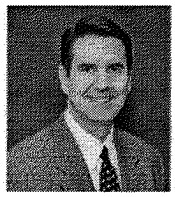
Member
Amandeep Basra
Acting Chief Executive Officer
Good Samaritan Hospital, Bakersfield

Member
Jeff Chinn, MBA
Interim Chief Executive Officer
Bakersfield Behavioral Healthcare Hospital, Bakersfield

Member
Russell V. Judd
Chief Executive Officer
Kern Medical, Bakersfield

Member
Michelle Oxford
President/CEO
Bakersfield Heart Hospital, Bakersfield

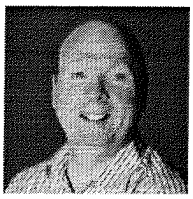
Member
Timothy McGlew
Chief Executive Officer
Kern Valley Healthcare District, Lake Isabella



Member
David Butler
President
Delano Regional Medical Center, Delano

Member
Tom Parker
Chief Executive Officer
Mammoth Hospital, Mammoth Lakes

Member
Bruce Peters
President/CEO
Mercy Hospital Southwest, Bakersfield



Member
Jim A. Suver, FACHE
Chief Executive Officer
Ridgecrest Regional Hospital, Ridgecrest

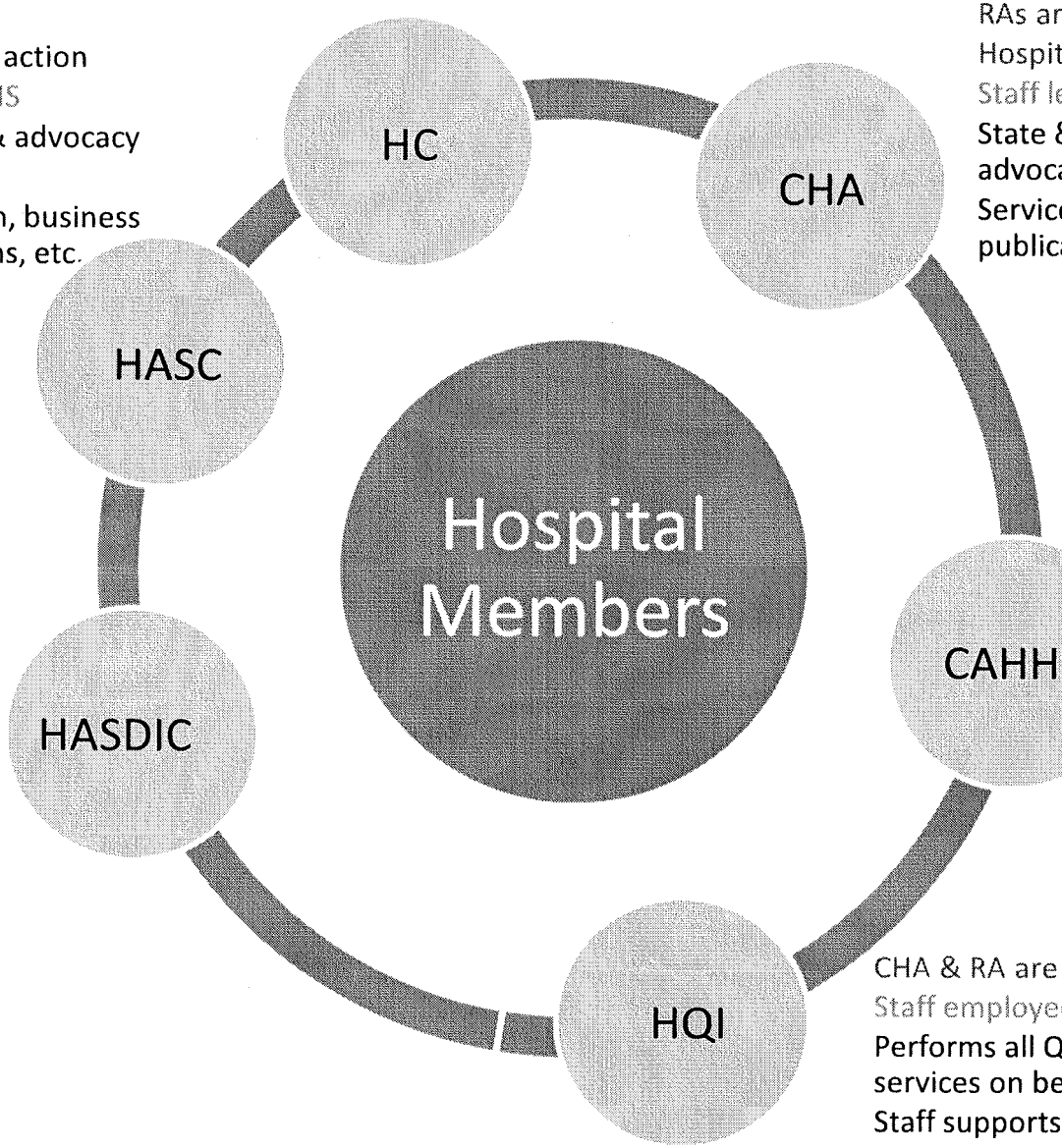
Member
Bruce Peters
President/CEO
Mercy Hospital, Bakersfield

Chair
Ken Keller
President/CEO
Bakersfield Memorial Hospital, Bakersfield

Member
Kelli Davis
Interim Chief Executive Officer
Northern Inyo Hospital, Bishop

California Association Structure

REGIONAL ASSOCIATIONS
Hospitals are members
Membership criteria & action
Staff leased from CAHHS
Local policy positions & advocacy
Support CHA in-district
Services, e.g. education, business partners, local programs, etc.



RAs are members
Hospitals are Constituent members
Staff leased from CAHHS
State & Fed policy positions & advocacy
Services, e.g. education, publications, etc.

CAHHS-California Association of Hospitals and Health Systems
HQI – Hospital Quality Institute
HC – Hospital Council of Northern & Central California
HASC – Hospital Association of Southern California
HASDIC – Hospital Association of San Diego and Imperial Counties

Hospitals are members
Staff employed by CAHHS
Original state hospital association
Holds major assets
Back office services to CHA & RAs

CHA & RA are members
Staff employed by CAHHS
Performs all Quality & patient safety services on behalf of CHA & RAs
Staff supports CHA's advocacy efforts

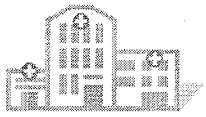
California's Hospitals

Did you know...

Hospital costs per capita in California are

6%

below the national average.



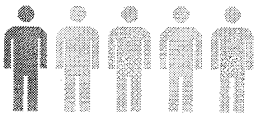
California is home to more than 400 hospitals.

93%

of Californians have some form of insurance coverage.

$20.5 billion

Each year, hospitals contribute more than $20.5 billion to support vulnerable populations — such as children, seniors, and low-income residents — in their communities.



In 2017 alone, **one in five** Californians received hospital care and patients visited hospital emergency departments **15.7 million** times.

Nearly **500,000** babies are delivered in California hospitals each year — and our state ranks FIRST nationally in keeping mothers safe during delivery.

Californians have the **second-highest life expectancy** in the nation — two years longer than the national average.

HOSPITALS ARE ECONOMIC ENGINES, RESPONSIBLE FOR **1.1 MILLION JOBS** AND $268 BILLION IN ECONOMIC OUTPUT.

California excels at keeping patients healthy — hospital admissions are **19% lower** than the national average and emergency department visits are **23% lower**.

Hospitals have spent billions on seismic safety, making their buildings some of the ***safest in the world.***

CALIFORNIA HOSPITAL ASSOCIATION | Hospital Council Northern & Central California | HOSPITAL ASSOCIATION OF SOUTHERN CALIFORNIA | HOSPITAL ASSOCIATION of San Diego & Imperial Counties

California Hospital Association

Your recap of key happenings for the week of June 29

Member Advocacy Call
July 7, 2020 | 8:30 a.m. (PT)
(800) 882-3610 Passcode 5010912#
Please mute your phone once you have been connected to the call by entering 61#.
Enter 60# to unmute your phone for comments/questions.

NEW THIS WEEK | SPOTLIGHT ON PRIORITIES | LEGISLATIVE UPDATE

NEW THIS WEEK

Federal Legislative Update

The House of Representatives passed two measures this week that are viewed as "messaging bills," given that the Senate is unlikely to consider them. The *Patient Protection and Affordable Care Enhancement Act* seeks to expand the Affordable Care Act (ACA) with greater subsidies for private health insurance, encourages states to expand Medicaid, and reverses Administration policies that undermine the ACA along with parts of their drug pricing bill that allow the federal government to negotiate drug prices. The *Moving Forward Act* seeks to spend $1.5 trillion to rebuild roads, bridges, transit, housing, and health care. The measure sets aside $30 billion for investment in increasing capacity in hospitals and community health centers; $10 billion of the funds is specifically designated for construction and modernization of hospitals.
Key dates: None at this time
Action needed: None at this time

SB 758 (Portantino, D-La Cañada Flintridge): Seismic Requirements for Hospitals

CHA continues to sponsor SB 758, related to seismic compliance. CHA staff will discuss an alternative approach to the 2030 seismic mandate on Tuesday's Weekly Advocacy Call. Given the operational and economic constraints of COVID-19, we must immediately consider the timing of the mandate. We should also consider the lessons of the current pandemic, as well as past disasters, when planning for future disasters.
Key dates: SB 758 will likely be heard in the Assembly Health Committee on July 28.
Action needed: CHA Alert coming next week

State Budget Update

Governor Newsom signed the 2020 Budget Act on Monday, along with a number of trailer bills. The final $202 billion budget closed a $54 billion shortfall caused by the pandemic-induced recession. The final budget did not include many of the proposals in the Governor's May revision, including the elimination or reduction in a number of Medi-Cal services, cuts the Legislature rejected. The final budget also did not include an earlier proposal that would have cut certain Medi-Cal managed care payments that would have directly impacted hospitals, a cut CHA opposed. Another round of budget negotiations is expected to take place in early August, after the July 15 tax deadline.
Key dates: None at this time
Action needed: None at this time

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SPOTLIGHT ON PRIORITIES

AB 890 (Wood, D-Santa Rosa) - Support

This bill would authorize a nurse practitioner who meets certain requirements to practice without physician supervision in specified environments. It would help to ensure millions of Californians are able to access health care services by allowing nurse practitioners to practice to the full extent of their education and training.
Key dates: AB 890 will likely be heard by the Senate Business and Professions Committee on July 24.
Action needed: Watch for a CHA Alert next week.

AB 196 (Gonzalez, D-San Diego) and AB 664 (Cooper, D-Elk Grove) - Oppose

These bills would create a conclusive presumption that the exposure to or contracting of COVID-19 arose in the course of employment for workers' compensation purposes. AB 664 applies to first responders and health care employees who provide direct patient care in an acute care hospital and includes all communicable diseases. AB 196 applies to all occupations deemed essential in the Governor's March 19 Executive Order, except those employees covered by AB 664.
Key dates: None at this time
Action needed: None at this time. Targeted advocacy will occur in the committee members' districts.

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LEGISLATIVE UPDATE

LEGISLATURE: The Assembly and Senate are in recess until July 13. The hearing schedules for policy committees in July have not been set. However, the Senate Health Committee is scheduled to meet on July 18, and the Assembly Health Committee is scheduled to meet on July 28.

CHA will provide an update of relevant bills on future member advocacy calls and continues to work on its legislative agenda. The latest on deadlines, amendments, and other information can be found in CHA's Legislative Update.

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NORTHERN INYO HEALTHCARE DISTRICT

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150 Pioneer Lane
Bishop,California 93514

(760) 873-5811

DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Jannalyn Lawrence, RHC & NIA Clinics Director

RE: Department Update

REPORT DETAIL

RHC

We welcomed Dr. Tim Brieske, MD to the RHC provider team on July 1. He will be working Thurs, Fri, Sat and is a great addition to RHC.

Our Car Clinic team worked their 100th day on Friday, July 3! They have served the District tirelessly, assessing patients for COVID-19 while combating every element from snow to triple-digit heat.

Three of our clinic providers (Dr. Leja, Dr. Wakamiya, and Alissa Dell, FNP) have been seeing patients at the Bishop Care Center regularly. This service is provided under the RHC umbrella so we are able to bill the all-inclusive RHC rate for each visit.

NIA

Specialty Clinic is working to expand urology coverage to twice monthly; this will include weekend clinics on Saturday and Sunday.

Tele-psychiatry with Dr. Bhojani has been up and running for over a month now, and is off to a great start. Patients are very happy with this service.

NORTHERN INYO HEALTHCARE DISTRICT

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150 Pioneer Lane
Bishop, California 93514

(760) 873-5811 Ext. 3415

DATE: July 2020

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Barbara Laughon, *Manager of Marketing, Communications & Strategy*

RE: Department Update

REPORT DETAIL

Old Business

Strategic Communications works to keep NIHD's community stakeholders informed of developments within the District while maintain a focus on key foundational messages as determined by The Board of Directors and the NIHD Executive Team. This has been done utilizing traditional media channels and through the development of educational outreach programs such as the Healthy Lifestyles Talks program and service-specific efforts such as Moonlight Mammograms and Colorectal Cancer Awareness Month. These successful outreach efforts involved a wide array of NIHD team members with extensive health expertise that draw community members to these events. It also affords the District an opportunity to work with trusted partners such as Toiyabe Indian Health Project, Southern Inyo Healthcare District, Southern Mono Healthcare District, and governmental agencies such as the County Board of Supervisors, the Bishop Paiute Tribe, and the Bishop City Council to raise healthcare awareness for all.

New Business

Like Departments across the District, Strategic Communications was inundated with communications needs as the COVID-19 pandemic settling in across the nation. Since March 10, Strategic Communications produced more than 50 NIHD Incident Command reports, averaging four to five pages in length, and an unknown number of COVID-related signs and various documents, and continues to serves the District staff in this capacity. Also, many thanks need to go out to the team members who participated in COVID educational opportunities be it through the local media, partnership with the county, or handling our standing segment on KIBS-FM 100.7 each Wednesday and Friday morning at 9 a.m. Another recent achievement includes the soft launch of the District's new website from Scorpion Healthcare with much thanks to District Project Manager Lynda Vance for her undying commitment to helping see the project through. Thes website will undergo continuous editing for the next few months. The next step is the development of a social media presence for NIHD, also through partnership with Scorpion Healthcare. Recruitment for the department's second employee, a Digital Marketing Strategist, is underway.

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150 Pioneer Lane
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(760) 873-5811

DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Rich Miears, Manager of Environmental Services & Laundry

RE: Department Update

REPORT DETAIL

Environmental Services:

The Environmental Service team operates Monday –Sunday 400am to 1230am. Our staff cleans areas from Birch Street, to the Joseph House to our OR's and PACU. We currently have 22 employees in ES with three vacant spots to fill. Due to Covid-19, some of the chemicals that we have been using for years are still hard to come by, so we have had to switch to alternate chemicals. We have just written a policy on the new Clorox 360 system. The Clorox 360 system is a new static cleaning technology. We will hopefully have it by the fall. This system will help ES with faster contact room clean turnovers.

Laundry:

The Laundry team operates Monday –Friday from 500am to 1630pm. We currently have 5 employees with staggered starts throughout the day. Our chemical line has been safe so far, but it has been hard to get certain linens to stock the hospital. The Laundry Department has taken on washable PPE coats and washable masks, which has saved NIHD in our disposable shortage during Covid-19.
We have signed a new tech service to service all laundry equipment quarterly. This service has been great because it has found and fixed issues that we had for years. This tech service has collaborated with our Maintenance Department to keep our equipment safe for our team and keeping our equipment in good running condition.

Other Information:

The Talent Pool currently has 5 employees and we're looking to move a few into fulltime spots at the hospital. This month we are looking to fill in the vacant spots when other Talent Pool staff take on fulltime positions. As of last week, the applicants in ADP for Talent Pool have been low.

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(760) 873-5811

DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Frank Laiacona, Director of Pharmacy

RE: Department Update

REPORT DETAIL

The pharmacy department is always busy and leadership keeps energy from becoming chaotic. We have several significant projects that are simultaneously ongoing.

1. Relocation of the pharmacy physical plant including USP 797 clean room facility.
2. Acquisition and implementation of the BBraun Smart Pumps a technological advancement for the district.
3. Upgrading the Omnicel Dispensing Units as current technology is sunsetting.
4. Cerner EHR implementation (soon) preparations.

Additionally the pharmacy department is actively increasing it's personnel participation in clinical team building.

We are operationally static during the SAR-COVID 19 crisis, fully staffed and motivated for what comes next.

The 340B program can have significant financial impact for the district, and our department is exploring the means to further optimize this government program.

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DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Mary Ellen Tillemans, Revenue Cycle Director

RE: Department Update

REPORT DETAIL

New Business

Admission Services

Registration teams continue to work intimately with clinical areas to assure current COVID 19 Patient Safety practices:

- Assisting, educating & masking arriving patients
- Assisting, educating & masking public
- Maintaining safe spacing of waiting areas
- Curbside Registration
- Making Lab Appointments

Business Office and Credit & Billing Info

Working with contract revenue cycle co. to optimize reimbursement of aged AR.
3 week status:

- $8.3 mil analyzed-worked
- $5.2 billed-pending adjudication
- $721,431 Reviews pending
- Constructive feedback
- Bad Debt analysis

Concentrated effort to process/move aged Bad Debt off AR (fragments of Athena poor process)

Charge Capture Team

District wide Charge Master/Revenue Policy and Procedures development
District wide review and maintenance of Charge Master
CMS Price Transparency Rule Preparation Project (01/01/2021)

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150 Pioneer Lane
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DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Greg Bissonette, Foundation Executive Director/Grant Writer

RE: Department Update

REPORT DETAIL

May 1st – June 30TH

FOUNDATION:

From May 1st through June 30th I've been working on a number of projects for the District. On the Foundation side, each month saw the holding of a board meeting. Those meetings culminated in the employee recognition event held from May 27th – 31st, where free treats were available to all staff in the freezer throughout the entire day. For the NOC shift employees, who would not be able to access the freezer due to the cafeteria being closed, individual gift cards from local coffee houses were provided to them. A new Foundation board member, Cheryl Underhill, was added to the roster and a donation of $5,520 was approved back to the District to offset the purchase of an AED for the Joseph House, CAREshuttle maintenance, and the cost of the food for the employee appreciation event.

GRANT WRITING:

On the Grant Writing side, a number of grants were reviewed and evaluated for submitting applications. Two were submitted for Opioid Use Disorder services through the RHC. Those totaled $972,000, over three years, to hire new and supplement current NIHD staff providing MAT and Harm Reduction services to our community.

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DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Patty Dickson, Compliance Officer

RE: Department Update

REPORT DETAIL

Old Business

The District Compliance Office continues to work to the Compliance Department Workplan, as submitted in the Compliance Department quarterly report to the Board.

- Audits of Employee Accesses
- Breach Investigations
- BAAs and Contract Reviews
- Policy Tech Program Upgrade Project
- Vendormate Project

New Business

The District Compliance office has been inundated with California Public Record Requests. Hundreds of thousands of documents are being reviewed for disclosure. Thousands have been disclosed.

Several breaches will be reportable in the month of July to California Department of Public Health and/or Health and Human Services Office of Inspector General.

Other Information.

Patty Dickson and Conor Vaughan have been working remotely for several months, and will continue to work remotely until remote workers are called back to campus following the COVID-19 lifting of restrictions.

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150 Pioneer Lane
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DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Bryan Harper, Acting ITS Director

RE: Department Update

REPORT DETAIL

ITS Old Business

ITS has been working on completing the network overhaul converting from 1gb to 10gb connections campus wide, Application upgrades, ITS contract negotiation, Security penetration testing, Citrix upgrades and working on Athena shortfalls to better take care of our patients which include confidential patient work flows. In addition, we have been working on our normal break/fix and preventative maintenance items.

ITS New Business

ITS will be moving forward with many projects in the coming months these include but not limited to overhauling of the NIHD wireless network, Cerner builds and prep work, application upgrades and implementation as well as upgrading over 100 computers and downsizing our printer fleet.

Clinical Engineering

Clinical Engineering has been working on the new IV pump project, EKG change out, and Cerner implementation. In addition, we have been working our normal break/fix and preventative maintenance. We have been exceeding our performance indicators as specified by the Joint Commission for PM completion (Non-Life support 95% Life Support 100%)

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DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Neil Lynch, Director of Materials Management

RE: Department Update

REPORT DETAIL

Old Business:

NIHD Purchasing department finished the fiscal year ramping up for the district's annual inventory. This is always a lot of work and plenty can go wrong, I am happy to report that everything went smoothly and timely.

New Business:

Purchasing is beginning work on the materials management item master. Specifically we hope to determine what items will be included in the Cerner build and what items should sunset with our legacy systems. This activity is a big undertaking but necessary for successful role out of the district's new systems.

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DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Thad Harlow, Director of Rehabilitative Services

RE: Department Update

REPORT DETAIL

Physical Therapy
We recently completed updates on our website that highlights information for all 3 disciplines. We are looking at final phase of the Adult Outpatient Clinic which will affect both PT and OT.

Occupational Therapy
We have an open Pediatric OT position that will allow us to expand our contracts with local school systems as well as backfill some of our adult outpatient caseload.

Speech Therapy
We have a new graduate Speech Therapist starting on 7/13/20. This position will support our expanded school contracts as well as more potential volume with Pioneer Home Health and Bishop Care Center.

Other Information
We are looking at options to move our Pediatric Occupational and Speech Therapy clinic to another space on campus to allow the District to provide expanded services on campus.

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DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Amy Stange, Cardiopulmonary Manager

RE: Department Update

REPORT DETAIL

The Cardiopulmonary department is a department within Diagnostic Services and is comprised of a cardiology component and a respiratory component. Cardiopulmonary includes diagnostic services such as Echocardiography, EKG, and pulmonary function tests (PFT) but also provides a very important therapeutic component associated with our respiratory therapists' treatment of a variety of respiratory conditions. Below is a summary in each key area.

ECHOCARDIOGRAPHY

Our Echo sonographer continues to promote the Transesophageal echocardiography (TEE) program. Terry Tye recently did a radio segment regarding the TEE program on KIBS. We have completed three TEE procedures since it went live in April of this year. We are nearing the end of a two-year training process with David Kim (Sonographer) and is the secession plan for Terry Tye's pending retirement. We expect the training to be completed and David to be registered to perform Echoes by the end of this month.

EKG

We are seeing our volume of stress tests and EKGs trending back to pre-Covid 19 levels. We have supplemented our staffing in the EKG department by hiring a per-diem EKG tech that will cover vacations in the department. We also have access to a core group of ancillary specialists that can provide EKG services to our patients when the department has competing patient priorities. Mortara EKG machines have been approved with the purchase of Cerner, and will allow for an electronic workflow for EKG acquisition and interpretation.

PFT

We know have two Respiratory Therapists trained to perform PFT for our community. Testing volumes for PFT are increasing, now matching pre-Covid 19 levels. Community support for this

testing platform continues to increase and is proving to be a valuable addition to our testing portfolio.

RESPIRATORY CARE

The Respiratory therapists continue to prepare for a surge related to Covid. Two new Vapotherm units have arrived to meet the needs of the community. Vapotherm is a non-invasive high-flow respiratory support system that reduces the work associated with breathing by providing high flows and high velocities of heated and humidified breathing gas through a simple nasal cannula. This therapeutic technique to assist patients by improving their ability to breathe easier. The Respiratory department is currently reviewing our current chargemaster in an effort to ensure that we maximize the accounting of all services provided within the department. In order to accomplish this, we are using the expertise of our business Partner, NThrive, as well as researching how other facilities account for their respiratory departments' services.

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(760) 873-5811

DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Lynda Vance, Project Management Specialist

RE: Department Update

REPORT DETAIL

OSHPD 8640 Management Engineering

In April, I started my new position as the District Project Management Specialist under the CEO. This moved me from under ITS to a separate department. I worked with Gen Owens to create a new Cost center for OSHPD and a budget. I also have participated in assisting with three rounds of interviews for new management positions.

Change Management

At the end of June, I began working with Bryan Harper, ITS interim Director, on re-working our processes with change management. We are working to move Change out of an ITS centric process to a District wide collaboration with Bryan and I co-chairing the Committee. More work continuing.

Projects *(this is a summary of the high-level work, not a complete list)*

Go Lives – 4 (Scorpion Website Go Live June 30; VendorMate - Credentialing Software Go Live July 6; Interpreter Intelligence (Language services scheduling software) Go Live July 13; Confidential charting in Clinics workflow Go Live July 6)

Actively Working – 5 (Amion Schedule Software (Med Staff) Go Live TBD; Cerner (EHR) Estimated Go Live May 2021; Bbraun Smart IV Pumps (Hosp) Go Live Aug 2020; PPM Navex (Upgrade policy manager) Go Live TBD; People Element (Workforce Intelligence Solutions and Analytics) Aug 2020)

Post Go Live – 4 (TEE -Trans Esophageal Electrocardiography; HealthFinch; Graphiumhealth -Anesthesia EHR; Tele-psychiatry with Regroup)

Closing – 3 (ADP - Cloud Analytics, MacroHelix 340b integration athena, 3M Server Upgrade, Lab PCR Testing additions)

Discovery – 3 (ADP to Replace Kronos Time areas (End of life Dec 2020); Nuance Powershare (Share DI portal); HEDIS (deficiency in Insurance Reporting)

Moves Completed - 15 (HIMS, Credit/ Billing, RHC Providers, Clinic Coordinator, Clinic Directors, RHC Auth and Ref, CFO/Payroll, Surgery Clinic Sched Coordinator, Cardiopulmonary offices, Project Management office, Perinatal Manager office, Patient Navigator, Care Coordination Manager, Care Coordination team.)

NORTHERN INYO HEALTHCARE DISTRICT

Improving our communities, one life at a time.
One Team, One Goal, Your Health!

150 Pioneer Lane
Bishop,California 93514

(760) 873-5811

DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Richard Ulibarri, Director of Human Resources

RE: Department Update

REPORT DETAIL

Old Business

The HR Department is fully staffed and working very well together. We have created a functional division of labor so we can all deliver high quality work to serve the district. Everyone is working 8 to 10 hours with greater efficiency, so we do have better work/life balance for our team. This is an important essential aspect to keeping the morale in this department high. Our goal and focus is to be a top notch department, subject matter expects, with cross-training and growth potential. The current state of the department is good.

Completed training for Managers/Directors on NIHD policies and procedures. Also completed training for the Dietary Department on harassment/bullying prevention.

New Business

Training - Ongoing

We are currently rolling out similar trainings for each department. NIHD has excellent Relias trainings, as well as, "in-person" facilitator trainings that are being rolled out to remind staff of important policies and Labor and Employment Laws. We will begin training staff in RHC, IT, Informatics, and eventually all other departments.

Employee Handbook

An updated employee handbook is underway with updated policies to make them current with existing law. We are sticking to the most recent benefits policies approved by the Board of Directors. This handbook will be given to the Board for review before publishing to the NIHD staff.

Union Negotiations

We are continuing with union negotiations and have completed most of this process. Additionally, we are working with the union on handling employee complaints and grievances. We want to partner with them to build rapport and together serve the best interests of NIHD and the community.

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150 Pioneer Lane
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(760) 873-5811

DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Larry Weber, Director of Diagnostic Imaging, Laboratory and Cardiopulmonary

RE: Department Update

REPORT DETAIL

Diagnostic Imaging

In an attempt to comply with social distancing requirements, Diagnostic Imaging is currently providing OP services to our community on a limited basis only. Although we have limited the number of appointments available for our services, DI is seeing about 85% of the volume that we experienced prior to the Covid 19 pandemic.

Staffing has been a challenge during the pandemic as we have had multiple technical staff members being on leave during this time. The remaining staff members are being recognized for their hard work and dedication to the community so we can accommodate the community demand for our imaging services.

Diagnostic Imaging has set up a drive through service that allows patients to stay in their car, register remotely, and have technical staff come and escort them into our facility so we can completed their imaging exam. Although utilization of this service has not been greatly utilized, we continue to offer the service to our community.

Laboratory

The Lab at NIHD has been very diligent in our work towards finding solutions for SARS CoV 2 testing for our community. Several options exist for testing, including in house PCR testing, sending specimens to our reference laboratory, and/or performing in house antibody testing. In an attempt to limit patient traffic in our hospital, our Lab Assistant I's (phlebotomy) have expanded their service delivery for specimen collection to include drive through collections and remote collections. While drive through collections are somewhat self-explanatory, remote collections involves our phlebotomists going to other OP departments and collecting patients'

specimens in that department. This alleviates the need for the patient to travel through our district for multiple service types.
In an effort to reduce patient overlap for services, the lab is requiring appointments for all collections. This is an effort to maintain social distancing by eliminating the potential of boluses of unscheduled patients coming in at the same time for laboratory services.
Although there was a significant decrease in volume in March and April due to Covid 19, the lab is now seeing similar volume as we experienced prior to the Covid 19 pandemic.

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150 Pioneer Lane
Bishop,California 93514

(760) 873-5811

DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Scott Hooker, Director of Facilities

RE: Maintenance, Security, Employee Housing, Property Management

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REPORT DETAIL

Maintenance

Our new Maintenance Manager (Jason Moxley) started on June 29th. The Maintenance team and myself are working to get Jason oriented to the facilities which consist of 14 acres with 11 buildings and a total square footage of approximately 120,000 square feet. I would like to thank Robert Ralston who did a great job as Interim Maintenance Manager for the last few months.

Our chiller plant will be upgraded in the months to come. As part of this, we are bringing in a temporary chiller to supplement as our current chillers are failing. We will also be updating the building maintenance program. This is the program that gives us control of all our buildings' utilities so that they do not run at 100% capacity at all times. This upgraded system will not only give us better control, but should help us save some money on utility bills.

Security

Security is currently operating with 6 officers, one less than we are used to. Security is onsite Sunday – Thursday 600p-330a Friday and Saturday noon-400a. We have a Pioneer Medical Association partners roundtable meeting scheduled for July 17th at 130pm.

Property Management

The building separation project continues to move along slowly. We are several weeks out from meeting the milestone. Once the milestone is met, we can submit the plans for the Pharmacy relocation.

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150 Pioneer Lane
Bishop,California 93514
(760) 873-5811

DATE: July 2020

TO: Board of Directors
Northern Inyo Healthcare District

FROM: Denice Hynd, Director of Nutritional Services

RE: Department Update

REPORT DETAIL

New Business

The Dietary Department has been supporting Inyo County efforts in feeding locals that are considered "persons under investigation" for COVID19 since April 2020. The Dietary Department receives a daily email from an Inyo County Health & Human Services staff member depicting the dietary needs of the individuals. The Dietary Department probes further by asking food preferences, food allergies, and dislikes. Once a brief food assessment has been conducted, the cooks prepare three meals, package them in disposable to-go containers, and an Inyo County representative picks them up and delivers the meals accordingly. The ability for the dietary staff to participate towards a solution in an unknown time has been rewarding and well-received. We look forward to supporting further servant leadership opportunities.

Old Business

Day to day operations for the dietary department continues to include:

- Feeding staff during lunch and dinner
- Coordinating with special event committees to organize and provide food during opportunities of celebration and acknowledgment
- Providing nuclear medicine meals
- Providing inpatient meals
- Maintaining survey readiness through environment of care observations and actions
- Enforcing social distancing recommendations while waiting and dining in the cafeteria

June 2020 Total Meals Served (patient + non-patient): 4417

NORTHERN INYO HEALTHCARE DISTRICT
PRESENTATION TO THE BOARD OF DIRECTORS
FOR INFORMATION

Date: The date of submittal of the form

Title: **CHIEF NURSING OFFICER REPORT FOR JUNE/JULY 2020**

Presenter(s): Tracy Aspel, BSN-RN
Chief Nursing Officer

Synopsis: Board update on Nursing Service Line for July 15, 2020 meeting

Prepared by: Tracy Aspel 7/4/2020
Name: Tracy Aspel, BSN-RN
Title: Chief Nursing Officer

Reviewed by: _____
Name
Title

Approved by: _____
Name
Title

FOR EXECUTIVE TEAM USE ONLY:

Date of Executive Team Approval: _____ Submitted by: _____
Chief Officer

July 2020 CNO Board of Directors Report

I am proud to honor **Brooklyn Burley, Assistant Nurse Manager ICU/Medical-Surgical Unit,** for earning her BSN. She completed this education milestone while working full time at NIHD.

CNO General Information-Tracy Aspel, BSN-RN:

- Recruitment for CNO replacement is in process. Job Description was updated and approved. Posting occurred on 6/1/2020. Interviews will occur in July. Interview team recommendations have been made.
- Incident Command for COVID continues to meet weekly. Tasks completed total 235 issues. Communication with NIHD team and community remains a high priority, with amazing support from Barbara Laughon. Medical leadership with Drs. Brown and Timbers (and many others) has been a key part of the success of this team. Infection Preventionist, Robin Christensen, continues to authorize decisions and collaborates with Inyo County Health Officer, James Richardson, MD.
- AED purchases for Birch Street Building and The Joseph House have been funded by The NIHD Foundation and The NIHD Auxiliary.

Case Management & Hospital Social Work: Melanie Fox, BSN-RN & Heather Edwall, LCSW:

COVID-19:

- We are surviving Coronavirus without patient overflow. YEAH TEAM!!!!! 😊 😊 😊
- Social Work (SW) is back to work on-campus full time.
- Case Management has remained on campus to provide direct care to patients for discharge planning during the pandemic.

Next Steps: Still need to get SW approved as a "Billable Provider " in case this need arises in the future through RHC -- could be a good opportunity to recoup some money and to be more flexible in providing services when/where needed.

PATIENT CARE:

- SW conducted 141 total visits/referrals with patients: 38 contacts were made for mental health reasons; 33 for substance abuse; and 14 (combined) CPS/APS reports made. Total contacts and CPS/APS reports are both way up from previous reporting period, although this may have to do with the way I am entering data as I get my system figured out!
- Advance Directive and POLST discussions are also way up from last report.
- In just the past few weeks I have been called several times by the Women's Clinic for help with patients who will soon be (or have recently been) inpatient in OB. I love being able to get to know patients sooner and think it helps their services go better over the long term.
- The perinatal department experienced another late-stage fetal demise during this reporting period, and another patient experienced the traumatic loss of his father amid some end-of-life miscommunications. Although SW left multiple messages with both of these family members they have not called back. SW continues to try to amass more grief support materials that could be relevant to our patients.
- SW utilized the translation line for the first time last month.

- I have added a "Frequent Flyer" category to track patients often seen by the ED. For now, we have 3 patients on it, and one is starting to reach out directly for support sporadically in between visits.

RESOURCE DATABASE:

- We are still working on getting internal contacts entered. SW continues to update the "COVID" section of the list as I have time.
- Dr. Helvie was awarded a grant for better communication of community resources, and OVCDC also secured a grant providing for a "Wellness Coordinator" to link families with available resources in the County. It is unclear if we will be able to partner with these entities to help them with their work (or vice versa), but conversations with each grant administrator have happened and we all continue to meet via the Resilience & Family Strengthening Collaborative to discuss how we can work together/be more efficient with what we already have.

Next Steps: Watch for a rollout email and training on search features, hopefully in the next 2 months and/or when we have about 400 entries. Staff will be asked for their suggestions via email to resources@nih.org, and can continue to notify list admins about changes, etc. by emailing this address in the future.

TRAINING:

- SW is currently attending Level II of AAP's online Trauma & Resilience training with members of the RHC Pediatrics team (1 hour every Wednesday).

Next Steps: CASA of the Eastern Sierra is Zooming a 4-hour symposium on Resilience on July 30.

COMMUNITY INVOLVEMENT:

- SW continues to participate in the County's Perinatal Taskforce, Resilience Collaborative, Family Strengthening Collaborative and Tobacco Coalitions when possible.
- Work continues through these collaboratives to get as many external agencies as possible to approve our "Joint ROI" (release of information). Form has been posted on the internet and a "Talking Points" memo attached to help NIHD staff use it.

ADMINISTRATIVE:

- SW has participated in NIHD's internal Pain Management committee (unsure of next meeting date due to COVID). In past 2 months SW was invited to speak at both OB and ED staff meetings. This may continue if staff feels it is helpful to be able to ask questions in these settings!

Emergency Department & Disaster Management: Allison Partridge-DON, MSN-RN, Gina Riesche-Manager, BSN-RN and Jenny Bates-Assistant Nurse Manager, MNE-RN:

- ED leadership remains active in the Emergency Operation Command (EOC) meetings to assure NIHD has a voice in decisions and is able to update Inyo County on what has been happening at the district.
- ED team achieved the Beta Quest for Zero, which allows for reduced insurance costs for the district. This involved every staff member in ED's participation in training. A review by BetaHealth was completed. (See attachment letter from BetaHealth.) The ED staff is to be congratulated on this accomplishment.

Acute/Subacute & Intensive Care Unit: Allison Partridge-DON, MSN-RN, Justin Nott-Manager, BSN-RN & Brooklyn Burley-Assistant Nurse Manager, RN:

- Pain Project Team continues to refine policies and procedures related to patient pain management. This team is led by Justin Nott, BSN, RN.
- Daily staffing huddles continue at 0700, during which important communication with the team occurs. The focus is often on safety of the patients.
- The team continues on with efforts to keep the unit quiet at night for our patients. This effort ties to improved patient satisfaction. Press Gainey scores (survey data from patients) is monitored closely by nursing leadership and shared with staff on the unit. Progress is being made in this area with "quiet sleep kits" for patients containing ear plugs, sleep masks and signage. Use of the "Yacker-Tracker" stop light device at the nursing station, which is green during quiet, yellow as noise is elevated and red when it is too noisy, has been embraced by the staff.

Perinatal Services: Allison Partridge-DON, MSN-RN, Julie Tillemans-Manager, BSN-RN:

- Perinatal Quest for Zero has been successfully completed. NIHD earned the recognition for completion of training and meeting the standards for quality improvement. This earns the district savings via BetaHealth. Congratulations to the entire perinatal team for this accomplishment!
- Data collection continues for the Baby Friendly USA annual certification review. This program supports lactation education of our nursing team. The result is more new Mom's choosing to breastfeed their newborns, which has long term health benefits.
- NEST transition of services is in process. Plan is to close the NEST location as of August 2. Team is meeting to determine plan for each service currently based in the NEST. NEST RNs will continue to work in perinatal positions after collaboration with the ASFCME Union. A day shift RN has been displaced from her current position; she has been offered a PM position.
- Julie Tillemans is working closely with Allison Partridge on leadership training within her new role of Manager. Julie grew up in Bishop, went to nursing school in Australia and came to NIHD as a new grad. She worked on the NIHD medical/surgical floor prior to transferring to perinatal services. She was trained and has demonstrated excellence in nursing. Julie's journey to leadership in nursing is an example of the opportunities available for staff at NIHD. We are already seeing leadership growth is just a few weeks.

Pre-operative, Post Anesthesia Care Unit (PACU) and Infusion: Ann Wagoner-DON, BSN-RN & Nicole Eddy-Manager, BSN-RN:

- Nicole Eddy will be leaving her manager position to train as an NIHD Surgical RN. Recruitment for the Manager position is currently in process. We thank Nicole for her leadership.
- The infusion center remains closed for the construction process. Wound care patient are being taken to an area within the diagnostic imaging department for care. Staff continues to do most infusions in the PACU area. The team has remained flexible, adapting to the patient needs as the priority.
- Wound care staff was highly praised by a long term patient. (See Attached letter.) Kathryn Erickson, MBA, BSN, RN, has pursued further education on complex wound management. She brings this knowledge to work with these patients and shares her newly learned information with her peers. She is an example of excellence in nursing here at NIHD.

Operative and Sterile Processing Units: Ann Wagoner-DON, BSN-RN & Jullie Allen-Manager, RN:

- Surgical cases are at about 75% or pre-COVID volume.
- Patients are pre-tested for COVID prior to surgery.
- The OR team will begin training a new surgical RN (Nicole Eddy) in August. This process takes approximately 12 months.
- Surgical team is very engaged in cost saving ideas. They met with CNO to discuss options on how they can make a difference fiscally. This engagement demonstrates a commitment to the district.
- OR inventory was completed in partnership with material management and fiscal services. The data showed a ½% variance or 18,000. This is amazing in comparison to prior years, per Genifer Owens, Controller. Congratulations to the surgery team.

Quality and Infection Prevention: Robin Christensen-DON, BSN-RN:

- Robin Christensen, BSN-RN, was recently promoted during a re-organization process to Director of Nursing. She will be responsible for District Quality, Clinical Informatics, Survey Readiness, Infection Prevention and Employee Health within her role.
- Alison Feinberg, BSN-RN, was hired with a start date of July 5, as the RN Manager of Quality, Informatics & Survey Readiness. She will report to Robin Christensen.
- Infection Preventionist job description has been developed and the position has been posted. This important role will be responsible to prevent and control infections for the district. This RN has significant responsibility and will be supported by Robin Christensen, who has performed this role for the district over the past 4 years.
- The reorganization will include the ITS Informatics staff joining the Clinical Informatics staff to create a unified team. This is essential to better serve the district for the future. The re-organization final date is yet to be determined.
- Employee health has begun preparation for "Flu Season".

Language Services: Jose Garcia-Manager:

- Interpreter Intelligence software program will go live at NIHD on July 13. Staff will be trained on this software the weeks prior to this launch. This software will allow Limited English Proficiency

(LEP) patients with Spanish as their primary language the opportunity to have live interpreters scheduled to support their interpretive needs in advance. This will allow the NIHD interpreters to plan time into their work for interpreting. We believe this will contribute to Patient satisfaction.

Respectfully Submitted,

Tracy Aspel, BSN-RN

Chief Nursing Officer

Northern Inyo Hospital

Overview:

In light of the COVID-19 pandemic that engulfed the world in early 2020, impacting BETA's members, Northern Inyo Hospital (NIH) rose to the challenge and completed the requirements for the 2019-2020 ED Quest year. Quest for Zero: ED is a two-tier program. Tier 1 focuses on education, providing individual participants with insight into their knowledge and judgment in a high-risk disease category seen in the emergency department. Tier 2 offers a menu of options to help set priorities based on risk-related trends specific to your organization or medical group. The program also includes other process improvement and risk reduction strategies worth exploring. The Tier 2 Triage options require a systematic look at the current triage process and to identify gaps and barriers in practice. Triage is a high-risk area and can set the tone for the rest of a patient's visit to the emergency department. Focusing on this area helps to ensure that the practice is following evidence-based practices and that there is limited drift in classifying patients.

Findings:

On June 2, 2020, NIH underwent its initial validation process for the ED Quest. This year, NIH focused its efforts on triage. During this validation, NIH, and more specifically, Gina Rieche, and Allison Partridge demonstrated transparency and passion for the work you are doing. I would like to commend you and the hard work the ED team is engaged in to ensure patient safety and quality outcomes for your patient population. During the validation meeting, several areas were touched on, and supporting evidence outlined NIH's commitment to this process.

Highlights:

During the validation meeting, there were a couple of areas that I want to call out as outstanding practices. The first area I would like to highlight is the utilization of an audit tool that has frontline nurses review the triage of other nurses. This provides those nurses not only to evaluate the ESI score of others but to self-reflect on their documentation. Additionally, it provides an opportunity for peer to peer team building.

The second area I would like to highlight is the process whereby standardized nursing procedures are reviewed yearly. This demonstrates not only NIH's commitment to quality, but also presents an opportunity to ensure that the procedures are being implemented as they are envisioned, and demonstrates compliance.

During the meeting, it was also determined that NIH had implemented direct bedding. This is a powerful tool that helps to minimize bottlenecks and to distribute the workload.

Recommendations:

As with any improvement initiative, there are areas of opportunity, and based on our meeting and a review of your documents, I would like to make a couple of recommendations.

One area that was identified that would enhance the success of your triage program is to track and trend the usage of standardized procedures. Many organizations use this as a way to 1) be sure that

there is continued compliance with usage without deviation, but also to identify if there are any order sets or procedures that can be removed due to limited use.

The second area of opportunity is to continue the auditing process and incorporate the audits into the competency process. This will assist in the continued standardization of the triage process and limit the opportunity for normal deviation.

Conclusion:

I want to thank you for the opportunity to discuss your triage program. It was a pleasure to sit and listen to your program, your process, and your willingness to share. BETA prides itself on working collaboratively with its members, and I appreciate your desire to work with me.

Sincerely,

Al Duke, M.B.A., B.S.N., RN, CPHRM, CEN, CPPS
Manager, Risk Management and Patient Safety

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Pamela Camille

P.O. Box 3363

Mammoth Lakes, CA 93546

June 27, 2020

To: Ann Wagoner

Dear Ms. Wagoner,

I wanted to let you know how wonderful the wound care staff is at Northern Inyo Hospital.

I began my treatment with NIH Wound Care on 4/7/2020. I had a cancer surgery wound in my left axilla that was about 4 cm. deep. Radiation burned it badly. I started wearing a wound vac a week later, and wore it almost two and a half months. My oncology surgeon says that my wound—now only 1.4 cm deep, can be completely healed with hyperbaric oxygen therapy, which I will begin in two days. It is suggested treatment will be complete on 7/24.

The wound care staff under and including Dr. Leja is the most caring and compassionate group of people I have known during my long cancer journey. All of them made me feel they were happy to help me, and that I was worthy of their extraordinary kindness and concern. The team is awesome and capable!

I must single out Kathryn Eriksen, who all the other members of the team praised for her innovative methods of dressing my wound. Unfortunately, I was allergic to the draping material, so Kathryn devised a way it was not necessary to use it. Kathryn is exceptional! Everyone, including me, sings her praises for this innovation.

July 15, 2020 Interim Chief Medical Officer Report to the Board of Directors

COVID-19 Update

NIHD's initial response to, and subsequent precautions, in conjunction with the Inyo county health officer, were successful in stemming the broad spread of COVID-19 in our community. Out of the 300 hundred plus employees and district staff tested only two were found to have antibodies to COVID-19 and these were individuals who were already know to have previously contracted the disease. Additionally, the community remained relatively spared from the disease and contact tracing and testing has been successful in inhibiting spread when a cluster is identified. NIHD put into place multiple provisions to address a possible surge of COVID-19 and the incident command team has identified and carried through on literally hundreds of action plans related to the pandemic. Despite these early successes the trends around the state and nationally are disheartening. As we move to reopen nothing with regard to the viruses pathogenicity or virulence has fundamentally changed and we are seeing marked spikes in cases. I am concerned that it is only a mater of time until this trend affects the healthcare district directly. In fact, as I write this report on July 1st, I can not help but wonder to what degree these predictions will be prescient by the time we convene

the July 15th board of directors meeting. At the time of this writing we remain in limited operations as outlined in the "COVID-19 Operations Action Plan" presented to the board in my report on May 20th, 2020. We very likely will need to consider shifting to essential operations depending on the impact locally of COVID-19 and the incident command has this conversation weekly. While the resurgence of COVID-19 is frightening I am encouraged by the plans the district has laid out and for a critical access hospital with a finite resource pool I feel we are as ready as possible to meet the stresses of a surge. It is paramount however that the community continues to remain vigilant and practices both masking and social distancing and I would ask the board for your help in community outreach and education to this effect.

COVID-19 Testing

Access to molecular tests such as PCR for in-house testing continues to be a challenge due to high demand and limited supply. We rely on this test for screening admissions, surgeries, and other high risk patients. With this shortage we have been able to utilize send out molecular testing for scheduled surgeries and outpatient testing and other less urgent indications but this has inherent limitations given the 3-5 day turn around time. We are also able to provide IgG and IgM antibody serum testing to evaluate for exposure to COVID-19. The district has begun offering IgG antibody testing to essential workers as defined by the State of California. Following an initial round of testing we hope to amplify the availability of this test for the benefit of the community more broadly.

Weekly Press Briefings

Dr. Stacey Brown and I continue to participate in weekly press briefing on Fridays at noon to discuss COVID-19 with local media. This has been well received and provides us a venue for supplying the community with accurate information regarding the disease and updates on NIHD's operations and services.

Contract Negotiations

As noted in my May 20th report to the board I have assumed the responsibility of physician contract negotiations. With the uncertainty regarding the CEO role over the past several months there are multiple contracts that require urgent attention. I am working with the rest of the executive team to address these as quickly as possible.

Urology Contract

I have renegotiated the urology contract with Dr. Ercolani's group, "Elite Robotic Surgical Consultants". Under the prior terms the district was losing 120,000$ per year. With the renegotiation we expect to initially at least break even and potentially make a small profit. ERSC will also now be coming twice monthly for 4 day rotations and will be providing scheduled clinic and possibly surgery on both Saturday's and Sunday's while they are on site. It is my hope, as well as Dr. Erconali's, that with the increased visitations we will see increased surgical volumes and thus revenue which will benefit both parties.

RHC Contacts

I am working to revise the base RHC physician contracts to include a more significant emphasis of productivity and quality. Prior agreements have included a 3% incentive for these metrics which has not been sufficiently motivating. My hope is that this revision will allow for increased earnings for physicians who meet these metrics while also generating more revenue for the district and providing better access to primary care in the community by encouraging more efficient clinic throughput. For the three physicians whose contracts were up for renegotiation on 6/30/20 we have extended them through the month of July.

Dr. Allison Robinson

Dr. Robinson will be providing coverage in August from the 9th-15th. I have written an contract reflecting Dr. Robinsons willingness and interest in per diem surgical coverage going forward.

Recruitment and Staffing

1. Dr. Tang from Barton Health has joined the hospitalist team part time and has thus far been well received.
2. Dr. Ma has been providing nocturnist coverage and is contracted with the district directly. He continues to be well received.
3. Dr. Engblade will be returning to NIHD full time in august and will be assuming the role of hospitalist director.

4. Dr. Jesionek has begun applying for privileges to provide full time hospitalist coverage.
5. Dr. Ricci will be joining pediatrics in October.
6. Dr. O'Neal, a general surgeon in Oakland, CA who is interested in providing approximately two weeks per month of general surgery coverage and assuming Dr. Harness's breast surgery practice, visited NIHD on 7/5-7/6.
7. Dr. Plank is a plastic surgeon in Florida with sub specialization in orthopedic hand surgery and dermatologic cancers who has been in interested in offering services part time in Bishop with a goal of transition to a full time practice and relocating to the area. We have been negotiating a contract.
8. Dr. Zukerman is a general surgeon with sub specialty training in hepatobiliary surgery currently working in Kalispell, MT who is interested in relocating. Will plan a site visit post COVID-19 restrictions.
9. Dr. Kasia Bartczak is interested in joining our hospitalist team this fall. She will do a site visit as soon as COVID-19 restrictions are loosened.
10. Dr. Gaskin has joined ESEP and began working in the ED in early July. Dr. Gaskin has relocated to the are and will be a full time physician.
11. Dr. Brieske has joined the RHC team.

Bronco Clinic

I have been working with WIFPLI to enroll the bronco clinic as a licensure exempt clinic (1206b) which would allow us to bill for services including mediCal, family PACT, and commercial insurance.

Provider Based Clinic Evaluation

Currently the NIA clinics are not licensed through the hospital and therefore the hospital is unable to collect a facility fee for services. WIPFLI gave a initial rough estimate that this could be a loss of revenue amounting to 1-2 million per year. The largest barrier to changing this designation is that the clinics need to be OSHPD level 3 compliant. Colombo construction has been asked to provide the district with a proposal for evaluating the NIA clinics for OSHPD level 3 compliance at which point a ROI will be completed to determine the cost effectiveness of transitioning to provider based hospital licensed clinics.

Marriage Family Therapist

When a new service line is offered through a RHC there is the option to renegotiate mediCal reimbursement rates for the entire clinic, not just that services line. A MFT and Dental hygienist are two services that result is a compensatory rate renegotiation, meaning mediCal can not deny the renegotiation request. Currently we are reimbursed around 274$ per RHC visit and it cost the district 410$ per visit. A rate renegotiation may help us to make up some of this difference. To this end we are attempting to hire a MFT to begin work at the RHC prior to the end of July. The district needs to demonstrate one fiscal year of MFT services to compel a rate renegotiation. In addition to the rate renegotiation this is also a beneficial service to the community and can be billed at the RHC rate.

Coding and Billing Audit

The executive team has been exploring the need for a coding and billing audit. From a clinical standpoint this would be helpful to ensure that our providers are coding appropriately so that we maximize charges for services provided while avoiding fraud. This is a challenge for providers as it is not taught as part of medical education and is generally "learned on the job". I suspect better eduction regarding coding for providers and a closer relationship between the coding team and providers is an area for increased revenue.

OR Block Schedule

I have been working with the surgery team to craft a block schedule for operative time for each surgical specialty. The goal is to minimize inefficiencies and cost while still providing each surgeon with ample and predictable OR time. Prior practices had allowed for frequent use of two OR's for convenience rather than necessity. This resulted in increased costs due to excess staffing needs.

Respectfully,

Will Timbers, MD

NORTHERN INYO HEALTHCARE DISTRICT
COMPLIANCE DEPARTMENT
POLICY AND PROCEDURE
Annual Review

1. Auditing of Workforce Access to Confidential Information
2. Business Associate Agreements
3. California Public Records Act Information Requests
4. Communicating Protected Health Information via E-mail
5. Disclosures of PHI over the Telephone
6. Employee Access to His or Her Own PHI
7. Sanctions for Breach of Patient Privacy
8. Sending Protected Health Information by Fax

NORTHERN INYO HEALTHCARE DISTRICT
COMPLIANCE DEPARTMENT
POLICY AND PROCEDURE

Title: **Auditing of Workforce Access to Confidential Information**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: April 30, 2018

PURPOSE: Establishes requirements for auditing access to confidential information including protected health information in accordance with Northern Inyo Healthcare District (NIHD) policy and state and federal regulations.

Definitions:

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

Confidential Information - protected health information (confidential medical information), workforce and employee health information, and proprietary information related to providers, financial data, trade secrets, business information, information protected by law and any other information pertaining to NIHD unless specifically designated as not confidential. Proprietary information is generally confidential information that is developed by the District as part of its business and operations. Such information may include, but is not limited to, the business, financial, marketing, and contract arrangements associated with District services and products. It also may include computer access passwords, procedures used in producing computer or data processing records, Personnel and medical records, and payroll data. Other proprietary information may include management know-how and processes; District business and product plans with outside vendors; a variety of internal databases, and copyrighted material, such as software. (Information published by governmental agencies or the NIHD Board of Directors on public sites is not considered confidential information in the form in which it is supplied and published. NIHD is governed by and complies with all freedom of information laws, such as the California Public Records Act and the Freedom of Information Act.)

Covered Entity – (for the purpose of this policy) a healthcare provider, a health plan, or a healthcare clearinghouse who transmits any health information in electronic form.

Minimum Necessary - covered entity must make reasonable efforts to limit the use, disclosure, and/or request for protected health information, and other confidential information to the minimum necessary (lowest amount) to accomplish the intended purpose of the use, disclosure, or request.

Need-to-Know - access to only the data he or she needs to perform a particular function (role based access).

NORTHERN INYO HEALTHCARE DISTRICT
COMPLIANCE DEPARTMENT
POLICY AND PROCEDURE

Title: **Auditing of Workforce Access to Confidential Information**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: April 30, 2018

Protected Health Information (PHI) - individually identifiable health information that is transmitted or maintained in any form or medium, including electronic PHI.

Electronic Protected Health Information or ePHI*:* Is PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all data that may be transmitted over the Internet, or stored on a computer, a CD, a disk, magnetic tape, jump drive (USB) or other media.

Breach - the unauthorized acquisition, access, use or disclosure of PHI and/or confidential information which compromises the security or privacy of the PHI or other confidential information.

POLICY:
Access to information systems is granted on a need-to-know basis and is based on one's role with NIHD.

Audits will be performed which evaluate whether information accessed was based on "minimum necessary" and "need-to-know" principles and standards and appropriate corrective action is taken as applicable.

AUDIT TYPES:

1. **Routine Audits** – Routine audits can include but are not limited to:

Audit	Description
Same Last Name	Workforce who access the record of a patient with the same last name
Same Department	Workforce who access the record of a co-worker who works in the same department
Workforce Hospital Admission	When a Northern Inyo Healthcare District employee is admitted to the hospital as a patient
Confidential Document	Workforce who access "confidential" documents
New Workforce Member	All access made by new workforce members are audited prior to the end of their 90 day introductory period
High Profile Individual	The patient is a newsworthy individual

2. **Audits for Specific Cause –** A request to audit for cause may come from various sources including but not limited to:
    a. Administration

b. Human Resources
c. Department Director/Manager
d. Board of Directors
e. Quality Assurance/Performance Improvement (QAPI) professionals
f. Security Officer
g. Patient or representative
h. Community member

Audits for specific cause are conducted in all systems applicable to services provided at NIHD.

Causes or reasons for specific audits include but are not limited to:

Audit	Description
Internal Concern	Concern is expressed by a co-worker, Administration, Department Manager, Security Officer or other user
Patient Complaint	Patients request an audit of access to their medical record
Employee Family Member Admission	When an workforce member's family member is admitted as a patient
Restricted Information Patients	Users who access a patient's record who requests restricted access
Follow-Up	Workforce who have been subject to corrective action(s) for accessing records inappropriately
Disciplined Workforce	Workforce who have been disciplined for accessing records inappropriately

3. **Random Audits –** Random audits may be performed on clinical systems and may be done to determine clean-up of inactive users.

Audits Investigated and Evaluated

1. The Compliance Department will review the audit results for potential breaches of patient privacy based and confidential information on "minimum necessary" and "need-to-know" principles. When questionable access is discovered on the audit report:

    a. A member of the Compliance Department will meet with the workforce member requesting information and an explanation for accessing the

patient or other information. For workforce members covered by a Memorandum of Understanding (MOU), any meeting will conform to the MOU's process. If further information is required based on the information received, meetings with additional workforce may occur. Follow up with any findings will be done with relevant workforce member(s).

b. If the audit findings reveal, as determined by the Compliance/Privacy Officer, activity that appears to constitute a breach of confidentiality, audit and investigation results for disciplinary determination will be reported to, at a minimum, the following:

   i. Human Resources and/or the workforce members' department manager/supervisor.
   ii. State and/or Federal agencies, in accordance with current law.
   iii. For each breach, the department manager/supervisor shall follow up with appropriate corrective action(s) as applicable to each finding and report such actions taken to the Compliance Department.
   iv. Department manager/supervisor shall submit copies of all documents for workforce corrective action(s) to the Compliance Department and the Human Resources department.

Audit Record Disposition and Retention

1. Audit reports are confidential documents. Copies of audit reports will be shared internally with Administration and management as necessary, and disclosed as required by law or for other business operations.

2. Audit for specific cause outcomes may be communicated to the requestor via mail or telephone, as determined by the Compliance/Privacy Officer.

3. Audit results will be retained according to state and federal regulations.

Availability and Retention of Documents

1. Audit documents will be made available to appropriate workforce members, as needed for review, discussion, and appropriate corrective action per NIHD policy and any applicable MOU.

Title: **Auditing of Workforce Access to Confidential Information**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: April 30, 2018

2. Audit documents will be made available to state and federal investigators upon request.
3. Audit documentation shall be maintained for no less than three (3) years.
4. Policy documents will be retained for no less than six (6) years from either the creation date or the last effective date, whichever is longer.

REFERENCES:

1. 45 CFR Part 164.308(a)(8) – Administrative Safeguards
2. 45 CFR Part 164.312 (a)(1) – Technical Safeguards
3. 45 CFR Part 164.308(a)(1)(ii)(D) – Administrative Safeguards
4. 45 CFR Part 164.312(b)– Administrative Safeguards
5. 45 CFR Part 164.316 – Policies and procedures and documentation requirements
6. TJC Standard IM.01.01.01
7. TJC Standard IM.02.01.01
8. TJC Standard IM.02.01.03
9. TJC Standard PI.03.01.01

Committee Approval	**Date**
Compliance Committee	4/5/2018
Administration	4/10/2018
Board of Directors	4/18/2018
Last Board Review	05/15/2019

Developed: 12/10/2013 KH
Revised: 9/1/2017, 3/29/2018PD
Reviewed: 12/16/15, 04/29/2019
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Business Associate Agreements	
Scope: District Wide	Manual: Compliance
Source: Compliance Officer	Effective Date: 10/1/2017

PURPOSE:

To establish guidelines for Northern Inyo Healthcare District to identify those relationships which meet the HIPAA definition of a "business associate" and provide direction on the process by which a business associates agreement will be established.

DEFINITIONS:

Business Associate (BA): an individual or entity, who is not a member of Northern Inyo Healthcare District's workforce, who performs functions or activities on behalf of, or provides services to, NIHD that involve access by the business associate to PHI

Business Associate Agreement (BAA): a written contract with the business associate that establishes specifically what the business associate has been engaged to do and requires the business associate to comply with the HIPAA Privacy and Security Rules' requirements to protect the privacy and security of protected health information

Covered Entity (CE): health plans, providers of health services, and clearinghouses that transmit any health information in electric form; for the purposes of this policy NIHD is a "provider" CE

Protected Health Information (PHI): information about health status, provision of health care, or payment for health care that is created or collected by a Covered Entity and can be linked to an individual (also called Individually Identifiable Health Information)

POLICY:

1. Business Associate Agreements will be established with all Business Associates who create, receive, maintain, or transmit PHI on behalf of Northern Inyo Healthcare District.

2. BAAs will meet the applicable requirements of 45 CFR § 164.504(e).

3. BAAs will be revised and re-signed as laws and regulations governing BAAs are updated and implemented by the Federal Government.

4. Departments currently receiving services from the Business Associate will, in collaboration with the Privacy Officer, identify Business Associates.

5. The Privacy Officer or Chief Executive Officer may execute Business Associate Agreements.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Business Associate Agreements	
Scope: District Wide	Manual: Compliance
Source: Compliance Officer	Effective Date: 10/1/2017

PROCEDURE:

1. For any new contractual agreements to be entered into by the District, District administration will ensure that the Compliance Department is notified to assess the need for a BAA.

2. The Compliance Department will send the BAA to the correct contact for the BA.

3. Once completed, the fully executed BAA will be maintained as a PDF in the Compliance Department electronic files. A copy of the BAA will also be sent to the Administration Office to be maintained with the contract for the BA.

4. The Privacy Officer will maintain an up-to-date list of Business Associates for compliance reviews and updates as required.

REFERENCES:

1. 45 CFR § 164 Subpart E
2. 45 CFR § 164.502(e)(1)

Committee Approval	**Date**
Compliance Committee	**9/5/2017**
Administration	
Board of Directors	**05/19/2019**

Responsibility for review and maintenance:
Index Listings:
Developed:
Revised: 8/31/2017
Reviewed: 12/16/15, 4/29/2019

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: California Public Records Act – Information Requests	
Scope: Administrative	Manual: Compliance
Source: Compliance Officer	Effective Date: 1/19/16

PURPOSE

This policy establishes guidelines for the employees of Northern Inyo Healthcare District ("District") to follow when there has been a request for information under the California Public Records Act.

POLICY

All California Public Records Act requests for Northern Inyo Healthcare District related information are to be referred to the Compliance Officer.

DEFINITIONS

California Public Records Act – The fundamental precept of the California Records Act is that governmental records shall be disclosed to the public, upon request, unless there is a specific reason not to do so.

Public Record – Any writing containing information relating to the conduct of the public's business prepared, owned, used, or retained by the entity regardless of physical form or characteristics.

EXEMPTIONS FROM DISCLOSURE

Key exemptions include:

- Preliminary drafts, notes, or memoranda not retained in the ordinary course of business.
- Records relating to "pending litigation". Documents that may be withheld under this section must be specifically prepared for litigation in which the District is party.
- Personnel, medical, or similar files where disclosure would constitute an "unwarranted invasion of privacy".
- Police files, including investigatory or security files compiled by any state or local police agency.
- Real estate appraisals or prospective public supply and construction contracts may be withheld until the property is acquired or all of the contract agreements are obtained.
- Exemptions based on prohibitions of disclosure under federal or state law, including provisions relating to privilege. This includes:
  - Attorney-client/attorney work product and doctor-patient privileges
  - "Official Information" privilege governing "information acquired in confidence by a public employee in the course of his/her duty and not open, or officially disclosed, to the public prior to the time the claim of privilege is made".
  - "Trade Secret" privilege. "Trade Secret" is defined as "information, including a formula, pattern, compilation, program, device, method, technique, or process, that: (1) Derives independent economic value, actual or potential, from not being generally known to the public or to other persons who can obtain economic value from its disclosure or use; and (2) Is the subject of efforts that are reasonable under the circumstances to maintain its secrecy.
  - Any other state or federal law protecting records, including HIPAA, FERPA, etc.
- The "Catch-all" or "Balancing Test"

- Is applied to protect records, even when there is no other exemption that would apply, where "on the facts of the particular case the public interest served by not making the record public clearly outweighs the public interest served by disclosure of the record".
- Includes the "Deliberative Process" privilege, to protect candid internal pre-decisional deliberations.
- Includes "burdensomeness". A request might be so burdensome, and the public interest in the material so small, that the balancing test might allow us to deny the request.
- Balances the public interest in disclosure against the public interest (not strictly the District's interest) in withholding.

PROCEDURE:

1. Requests to inspect and copy public records should be made directly to the Compliance Office.
2. The District is entitled to review and redact records before producing them to the requester.
3. Public records are open to inspection during the normal business hours of the Compliance Office. The "open to inspection" provision does not require that an individual be given immediate access to the records upon request. In all cases, the records would first need to be located and collected, possibly from multiple locations.
4. An appointment to inspect records may be necessary under these circumstances. If the requester requests access to a large number of documents, the requester may need to make additional appointments to complete the document inspection process.
5. Upon either the completion of the inspection or the oral request of District personnel, the person conducting the inspection shall relinquish physical possession of the records.
6. Persons inspecting District records shall not destroy, mutilate, deface, alter, or remove any such records from the District.
7. The District reserves the right to have District personnel present during the inspection of records in order to prevent the loss or destruction of records.
8. The operational functions of the District will not be suspended to permit inspection of records.
9. The District is required to determine within 10 days (can be extended to 24 days for voluminous/complex requests) after receipt of a records request whether or not the requested records exist and/or are subject to disclosure, and to notify the person making the request of the reasons for that determination. The records themselves are not required to be released in 10 days. At the time of making a determination, the District will provide a good faith estimate of when the records will be available.
10. The District is required to "assist the member of the public in making a focused and effective request that reasonably describes an identifiable record".
11. The District may not consider the identity of the requester or the purpose for the request, in making its determination.
12. The District does not have to create new records or answer questions. The California Public Records Act simply requires access and disclosure of existing records. However, we are required to extract data from a database upon request.

Title: California Public Records Act – Information Requests	
Scope: Administrative	Manual: Compliance
Source: Compliance Officer	Effective Date: 1/19/16

13. Copies will be provided upon request, at a cost of $0.25 per page for scanned or paper copy or $15.00 for USB electronic format. The requester may inspect records at no cost. Staff time for searching, collecting, reviewing, and redacting documents, is not considered to fall within the "direct cost of duplication". Pre-payment for all copying/scanning, electronic format costs are required before release of public records.

REFERENCES:

1. California Government Code §6250, 6252(f), 6253.9
2. "The ABC's of Privacy and Public Record", by Maria Shanle
3. www.thefirstamendment.org/capra.html

Approval	**Date**
Board of Directors	5/17/2017
Last Board of Directors Review	**5/15/19**

Developed: 1/19/2016
Reviewed: 5/1/2017
Revised: 5/4/2018, 4/29/19
Supercedes:

Responsibility for review and maintenance: Compliance Officer

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Communicating Protected Health Information Via Electronic Mail (Email)**	
Scope: **District Wide**	Manual: **Compliance**
Source: **Compliance Officer**	Effective Date: January 17, 2019

PURPOSE: To describe the procedures governing a workforce member's use of a Northern Inyo Healthcare District (NIHD) electronic mail (email) system. It also defines the steps that must be explained to, and taken by NIHD, patients who wish to engage in email with an NIHD workforce member.

DEFINITIONS:

Access: the ability or capacity to read, write, modify, or transmit information, or otherwise make use of any system resource

Restricted Information: Describes any confidential or personal information that is protected by law or policy and that requires the highest level of access control and security protection, whether in storage or in transit. This includes PHI (Protected Health Information)/ePHI (electronic protected health information), confidential information, and other Medical Staff and Allied Health Professionals (AHPs) communication as defined in this section.

Electronic Protected Health Information or ePHI: Is PHI that is transmitted by electronic media or is maintained in electronic media. For example, ePHI includes all data that may be transmitted over the Internet, or stored on a computer, a CD, a disk, magnetic tape or other media.

Internal Email - is defined as being sent from and delivered to the NIH.org domain (both sender and recipient's email addresses end with "@nih.org")

Remote Access: the ability to access Northern Inyo Healthcare District network systems from a remote location; this includes home office users, non-Northern Inyo Healthcare District facilities, and business associates

Workforce: Persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

POLICY:

1. NIHD does not permit email of unencrypted Protected Health Information (PHI) outside of the NIH.org domain. The ONLY exception to this policy is if the patient has specifically requested, in writing or an email, the PHI be sent to an email address provided by the patient, in an unencrypted email.
2. PHI may be communicated internally following the procedures as outlined below.
3. All automatic forwarding, redirection, or other automated delivery or pickup of NIHD email, to external destinations is explicitly prohibited.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Communicating Protected Health Information Via Electronic Mail (Email)**	
Scope: **District Wide**	Manual: **Compliance**
Source: **Compliance Officer**	Effective Date: January 17, 2019

PROCEDURE:

1. **Communicating PHI via Email internally**
   Email of PHI will be permitted, internally, at NIHD if the following safeguards are implemented:

   a. NIHD shall use the following safeguards when communicating PHI in or attached to an internal email message:
      (1) Do not use auto-forward for NIH.org emails to a private/personal email account.
      (2) PHI should not be transmitted in the subject line of the email message.
         a. This includes the name of the patient or a medical record number. It is acceptable to have PHI in the body of the email as necessary for identification purposes for the reader.
         b. If you have an attachment, the name of the attachment file will be in the subject line. Delete any patient identifier in the subject line.
      (3) The user should verify before sending an email message that he/she has attached the proper attachment.
      (4) Before transmitting the email message, users should double-check the message and any attachments to verify that no unintended information is included.
      (5) Users who communicate PHI via email will comply with all other NIHD policies and procedures including, but not limited to, the Minimum Necessary Policy.

   b. Any user who is unsure whether an email message or attachment contains PHI should contact his/her supervisor or the HIPAA Privacy Officer before initiating the email communication.

2. **Communicating PHI with Patients**

   a. Patients have the right to request that NIHD communicate with them via email, provided NIHD can do so without compromising patient confidentiality.
   b. If a patient requests email communications containing their PHI, the individual receiving the request must document patient authorization and the email address provided. NIHD workforce MUST inform the patient that unencrypted email is not a secure format for information. It is similar to regular mail, someone can open it and get the information. The patient can choose to receive communications via encrypted (secure) email, if they prefer.

      Email addresses should be read back (including spelling it out) when entering the information in the EHR.

      A confirmation email should be sent to the address prior to using it to communicate PHI to ensure the correct email address is used. Do not send PHI to an unverified email.

      Sample text for verification email:

Greetings,
You have requested communication via email.
I am sending this email to confirm that I have your email address correct. I am attempting to reach Firstname Lastname. Please reply to this email if it has correctly reached the right person.

Additionally, please let me know if you prefer to receive information encrypted (more secure, better to protect your private information) or unsecured (which is more like regular mail or a postcard).

Respectfully,
Name of employee

c. Confirmation email should be sent to HIM (Health Information Management) department to be added to the patient medical record authorizations.
d. NIHD workforce members reserve the right to deny a patient's request to communicate with him/her via email, however, the workforce member must forward the patient request to a supervisor.
e. PHI sent to patients shall meet all criteria listed in Section 3, Communicating PHI Via Email Externally.

3. Communicating PHI via Email Externally

a. All email that contains PHI sent to external destinations shall be encrypted prior to delivery, in a manner adherent to NIHD Information Technology (IT) Department requirements.
    i. To encrypt (secure) an email containing PHI or sensitive information type SECURE: at the beginning of the subject line. The word SECURE must be in all capital letters and must be followed by a colon (:). Use caution when replying and forwarding to make certain that the SECURE: is at the beginning of the subject line.
    ii. To intentionally send an unencrypted (unsecured) email type NOENCRYPT: at the beginning of the subject line. The word NOENCRYPT must be in all capital letters and must be followed by a colon (:). Use caution when replying and forwarding to make certain that the NOENCRYPT: is at the beginning of the subject line.
b. The email message will include the following confidentiality notice. This notice is automatically added to all emails sent outside the NIH.org domain and does not require sender interaction.
"This electronic message is intended for the use of the named recipient and may contain confidential and/or privileged information. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or use of the contents of this message is strictly prohibited. If you have received this message in error or are not the named recipient, please notify us immediately by contacting the sender at the electronic mail address noted above with a copy to compliance@nih.org and destroy this message"

4. Ownership of Electronic Mail

a. The email systems at NIHD belong to Northern Inyo Healthcare District.

b. NIHD reserves the right to override individual passwords and access the email system at any time for valid business purposes including, but not limited to, PHI security investigations or at the request of Human Resources.

References:

1. https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providers-to-use-email-to-discuss-health-issues-with-patients/index.html
2. 42 CFR 164.522 (b)

Committee Approval	**Date**
Administrator	**1/14/2018**
Board of Directors	**1/16/2018**
Last Board approval	**1/15/2020**

Developed: July 2013
Revised:11/9/2018
Reviewed: 12/16/15

NORTHERN INYO HEALTHCARE DISTRICT
COMPLIANCE
POLICY AND PROCEDURE

Title: **Disclosures of Protected Health Information Over The Telephone**	
Scope: District Wide	Manual: Compliance
Source: Compliance Officer	Effective Date: 12/1/2017

PURPOSE: In certain instances, using the telephone to communicate with a patient or to respond to requests for a patient's protected health information (PHI) is necessary or more convenient for the patient than communicating via mail or e-mail, or having to come to Northern Inyo Healthcare District (NIHD) in person. In order to do so while maintaining patient privacy and minimizing workforce disclosures to incorrect parties, NIHD has certain rules in place which must be followed.

POLICY: Workforce members should attempt to limit, to the extent practical, PHI communicated over the phone. When necessary to disclose PHI over the telephone, NIHD has procedures that must be followed.

PROCEDURES:

1. **Requests from or disclosures to a caller stating he/she is a patient**
   If a caller states he/she is a patient and he/she is requesting PHI about himself/herself, the workforce member will provide the PHI when they have confirmed the caller is the patient, using two patient identifiers.
   a. The workforce member will, prior to disclosing PHI, ask specific questions that could only be answered by the patient. For example, the patient's date of birth, address, father's name, or mother's name.
   b. If the workforce member knows the patient and the patient's voice, and recognizes the voice on the telephone as being that of the patient, verification with two identifiers shall be used to ensure the workforce member is in the correct record.
   c. The workforce member may elect to place a return call to the patient using the telephone number documented in the patient's record rather than immediately disclosing the patient's PHI to a caller initiating the telephone conversation.

2. **Requests from or disclosures to a caller who is not the patient**
   If the caller states he/she is an immediate family member (e.g. father, mother, child, or sibling) of the patient, the workforce member will refer to the patient's record for documentation (Authorization for Release of Information) to determine what information may be provided to this individual.
   d. If the caller states he/she is a friend, relative, or acquaintance of the patient or if the caller is unrelated to the patient (e.g. the patient's employer, law enforcement, or a reporter) the workforce member will:
      i. Not disclose PHI without the patient's permission; or
      ii. Provide only directory information about the patient. Directory information is defined as:
         1. The patient's name
         2. The patient's location

3. The patient's condition described in general terms that do not communicate specific PHI about the patient ("good", "stable", "critical", etc.)

3. Calls to a patient's home

Workforce members may not leave messages regarding treatments or diagnostic testing information on a patient's answering machine. Individuals leaving appointment reminders may only provide the name of the provider, the office phone number, the date and time of appointment, and/or the location.

4. Documenting disclosures made over the telephone

If PHI is disclosed to a caller, the workforce member will document the disclosure in the patient's medical record.

Questions

Questions about disclosure of a patient's PHI over the telephone should be directed to the workforce member's supervisor or the HIPAA Privacy Officer.

Approval	Date
Compliance Committee	**10/24/2017**
Administrator	**11/10/2017**
Board of Directors	**11/15/2017**
Last Board of Directors Review	**05/15/2019**

Developed: July 2013
Revised: 10/20/2017
Reviewed: 12/16/15, 04/29/2019

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Employee Access to His or Her Own Protected Health Information*	
Scope: District Wide	Manual: Compliance
Source: Compliance Officer	Effective Date: 9/1/2017

PURPOSE:
To provide all Northern Inyo Healthcare District patients with the same access to protected health information.

POLICY:
Northern Inyo Healthcare District maintains protected health information on each patient in either paper or electronic medical record format. Employee access to his or her own protected health information is treated in the same manner as that of every patient.

Definitions:
"Medical Record" means any item, collection, or grouping of information that includes protect health information and is maintained, collected, used, or disseminated by or for a covered entity.

"Employee" means students, volunteers and any person whose work performance is under the direct control of Northern Inyo Healthcare District.

"Protected Health Information" (PHI) means individually identifiable health information that is transmitted or maintained in any form or medium, including electronic PHI.

"Health Insurance Portability and Accountability Act" (HIPAA) means the Standards for Privacy of Individually Identifiable Health Information. This rule includes standards to protect the privacy of individually identifiable health information.

PROCEDURE:

1. In order to access his or her own protected health information, an employee must follow the regular procedure of the facility. An employee is not permitted to access his or her own information by use of clinical information systems or any other paper or electronic system.

2. An employee may obtain a copy of his or her own medical record in the Medical Records Department following facility policies and procedures.

3. Employee records will be subject to random HIPAA privacy and security audits for inappropriate access.

4. Inappropriate access to an employee's own PHI may result in disciplinary action up to and including termination.

References: 45 C. F. R. §§160 - 164.524 et seq. (HIPAA)
California Confidentiality of Medical Information Act –

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Employee Access to His or Her Own Protected Health Information*	
Scope: District Wide	Manual: Compliance
Source: Compliance Officer	Effective Date: 9/1/2017

Civil Code § 56-56.16 California Health and Safety Code §§ 123110 - 123130
Title 22 C.C.R; California Code Regulation §§ 70751(b) and 71551(b)

Approval	**Date**
CEO	
Board of Directors	8/16/17
Last Board of Directors Review	05/15/19

Developed: 5/14
Revised: 8/1/2017
Reviewed: 12/16/15
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Sanctions for Breach of Patient Privacy Policies**	
Scope: District Wide	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

PURPOSE:

To comply with 45 CFR 164.530(e)(1) which requires "a covered entity must have and apply appropriate sanctions against members of its workforce who fail to comply with the privacy policies and procedures of the covered entity"

POLICY:

Definitions:

"Sanction" means training with documentation in the employee record, disciplinary action or termination.

"Workforce" means persons whose conduct, in the performance of their work for NIHD, is under the direct control of NIHD or have an executed agreement with NIHD, whether or not NIHD pays them. The Workforce includes employees, NIHD contracted and subcontracted staff, NIHD clinically privileged Physicians and Allied Health Professionals (AHPs), and other NIHD health care providers involved in the provision of care of NIHD's patients.

"Inadvertent Violation" means an error that results in a breach of privacy made while following District policies and procedures.

"Negligent Violation" means a breach of privacy made while incorrectly following or not following District policies and procedures.

"Deliberate Violation" means a breach of privacy made while willfully not following District policy.

"Protected Health Information" or "PHI" means any individually identifiable health information regarding a patient's medical or physical condition or treatment in any form created or collected as a consequence of the provision of health care, in any format including verbal communication.

"Unauthorized" means the inappropriate acquisition, access of, use or disclosure of protected health information without a direct need to know for medical diagnosis, treatment, or lawful use as permitted the California Medical Information Act or any other statute or regulation governing the lawful access, use, or disclosure of medical information. (California Health and Safety Code Sec. 2 1280.15)

"Malicious" means with intent to harm or with intent to gain personally.

Breach Levels by Incident

1. **Minor breach**
   A Minor Breach is inadvertent and non-malicious in nature.
   Examples include but are not limited to: distributing, emailing or faxing protected health information to the wrong individual unintentionally.

2. **Moderate breach**
   A moderate breach is negligent in nature. The intent of the violation is unclear and the evidence cannot be clearly substantiated as to malicious intent.
   Examples include but are not limited to failing to log off computer systems, failing to check a guarantor or insurance provider when registering a patient, failing to check that the provider selected for an outpatient order matches the written order presented by the patient, faxing protected health information to an unverified fax number, or a pattern of minor violations.

3. **Major/severe breach**
   A major/severe breach is a deliberate violation that purposefully or maliciously violates a patient's privacy or disregards Northern Inyo Healthcare District policy.
   Examples include but are not limited to: releasing or using data for personal gain, destroying or altering data, purposefully accessing or attempting to gain access to patient information which the employee has no work related need to access, maliciously attacking or hacking District information systems, releasing patient data with the intent to harm an individual or the District, or a pattern of repeated moderate violations.

Whistleblower Protection

a. Neither the District nor any employee of the District may intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual who reports any conduct that is unlawful or otherwise violates professional or clinical standards including, but not limited to the reporting of conduct that results in the breach of privacy of any patient of Northern Inyo Healthcare District.
b. Proven violation of this section will result in Immediate Loss of Employment.

Disciplinary Action

Disciplinary action, up to and including termination, based on recommended corrective actions in **Attachment A "Sanctions for Breach of Patient Privacy – Incident Severity Scale**", will be taken for any workforce member for a violation of privacy and security policies and procedures. Northern Inyo Healthcare District prohibits the use of District property for illegal purposes and for purposes not in support of Civil Code 56.36/Health and Safety Code 130200 and 1280.15.

ATTACHMENT A

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Sanctions for Breach of Patient Privacy Policies**	
Scope: District Wide	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

Sanctions for Breach of Patient Privacy – Incident Severity Scale

Guidelines with recommended corrective actions, once an incident and individual are identified.

		Action Level		
Level	**Intention of the Individual** Responsible for the privacy breach	**Minor**	**Moderate**	**Major/Severe**
A	**Inadvertent** • Inadvertent mistake	1	1	2
B	**Negligent/Unintentional** • Carelessness or negligence • No known or believed intent	2	3	3-4
C	**Intentional** • Due to curiosity or concern	2	3	3-4
D	**Intentional** • Malicious intent, including accessing or use of information in a domestic dispute • Personal financial gain • Willful or reckless disregard of policies, procedures or law	4	4	4

Action Level:

1. Re-training and/or coaching memo

2. Counseling memo, verbal warning, warning letter, or suspension (length to be determined by circumstance)

3. Suspension, or written warning indicating that any further conduct resulting in a breach of privacy will result in termination

4. Termination

Title: **Sanctions for Breach of Patient Privacy Policies**	
Scope: District Wide	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

Action Level Modification:

Action level may be modified by the consensus of the Privacy Officer, Human Resources Director, and the employee's manager by considering the following:

1. Previous history or corrective action (level of action may increase based on repeat offenses)
2. Whether or not the individual caused an inadvertent violation based upon a situation or operation that the individual did not know caused the breach.

References

1. 45 CFR 164.530(e)(1)
2. California Health and Safety Code Sec. 2 1280.15
3. Civil Code 56.36
4. California Health and Safety Code 130200

Approval	**Date**
Compliance Committee	10/24/2017
Administration	11/10/2017
Board of Directors	11/15/2017
Last Board of Directors Review	5/15/19

Developed:
Revised 12/2013 KH, 10/20/2017 PD
Reviewed 12/16/15, 4/29/2019
Supersedes

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Sending Protected Health Information by Fax**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

PURPOSE:
To provide guidance for sending protected health information (PHI) by fax to prevent the occurrence of a breach of patient information.

POLICY:

1. PHI may only be faxed by NIHD personnel who have been trained in this policy.

2. Preprogrammed fax machines shall undergo a fax number verification prior to being released for use by staff. Requests for a programmed fax number shall be submitted through the IT Helpdesk ticket system.

    a. A verification request fax will be sent to each requested fax number for any machine by the Compliance department prior to release to staff.
    b. The verification request fax will contain at least the following statement or words of similar import: "This fax verification is intended for _____. If the intended party has received this fax, check here and fax back to _____. If someone other than the intended party has received this fax, check here and fax back to _____."
    c. Once verified, the fax number verification form will be sent to the IT department for programming. IT will program and send visual verification to the Compliance Department.
    d. The preprogrammed fax machine will not be released for staff use until all preprogrammed fax numbers have been verified in accordance with this section.
    e. Compliance will notify of completion of programming and availability of programmed fax button for use.

3. The Compliance Department will be responsible for determining that a preprogrammed fax machine can be released to staff in accordance with this policy.

4. Multi-use fax machines are defined as capable of copying as well as receiving and sending faxes. Multi-use fax machines may only be put in service if an alarm is set to notify operators of a fax being received.

5. Prior to faxing PHI, NIHD personnel must either:
    a. Verify the fax number as being accurate and correct for the intended recipient, or
    b. Utilize a preprogrammed fax number by accessing the number memory of the fax machine or faxing program.

6. Verification of a fax number must be done through one of the following means:
    a. Contacting the intended recipient (or the recipient's office personnel) and reading back the number to that individual; or
    b. Sending a test fax asking for the recipient to send a verification fax back.

7. NIHD personnel performing fax verification must document
    a. Who verified the recipient's fax number for the recipient; and
    b. Which NIHD person performed the verification; and
    c. The date and time of verification.

Title: **Sending Protected Health Information by Fax**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

FAXING TO AN UNINTENDED RECIPIENT

8. NIHD personnel who send faxes of PHI in accordance with this policy, but through human error still send a fax to an unintended recipient, must report the mistake to the NIHD Compliance Officer via phone or via email **as soon as the mistake is recognized** and also must complete a PHI Breach Notification Form. The PHI Breach Notification Form is available on the Hospital Intranet. Note: The report to CDPH requires that the violator be named in the report.

9. NIHD personnel who are notified by an unintended recipient that they received a fax containing PHI must report to the Compliance Officer by phone or email, as soon as possible, but not later than the end of their shift. The employee who receives this notification from the unintended recipient must report the following:
    a. The name and telephone number of the unintended recipient.
    b. The time and date of the notification by the unintended recipient.
    c. A description of the PHI that was received including the patients name and the general type of PHI (doctors' orders, test results, etc.).
    d. The disposition of the PHI (e.g. the recipient will send the document(s) back to us, the recipient will deliver the document(s) to the hospital, the recipient will shred the document(s)).

10. If the unintended recipient is a hospital, medical or dental practice or facility, NIHD employees receiving notification from those offices may instruct the offices to shred the documents or send them to the NIHD Compliance Officer.

11. If the unintended recipient is other than a hospital, medical or dental practice or facility, then the NIHD employee **must** ask the recipient to send the documents to the NIHD Compliance Officer. Shredding is not to be recommended.

REFERENCES

1. CA Health and Safety Code 1280.15
2. 42 USC Section 17939

Committee Approval	**Date**
Compliance Committee	**10/24/2017**
Administration	**11/10/2017**
Board of Directors	**11/15/2017**
Last Board of Directors Review	**1/15/2020**

Revised: 2-14-12, 10/4/2017
Reviewed: 1/18/17, 10/17/2017; 1/16/2019
Supersedes:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Sending Protected Health Information by Fax**	
Scope: **District Wide**	Manual: **Compliance**
Source: Compliance Officer	Effective Date: 12/1/2017

Responsibility for review and maintenance: Compliance Officer
Index Listings: Fax, Faxing, PHI
Initiated: 4-9-2010

June – ED and Disaster (Gina/Jenny)
Policies for Board Review

Page 1 of 4 (78 items) 1 2 3 4

Type	Title
	Bite Guidelines, Animals
	Code Blue (Cardiac Arrest) Documentation
	Communicable Disease Prevention Of Pre Hospital Care Worker
	Computer Downtime Emergency Department
	Computer Interface Down Time Emergency Department
	Consent for Medical Treatment
	Coroner's Cases
	Dead on Arrival*
	Dental Emergencies in the Emergency Department
	Disaster Management Committee
	Discharge Instructions Emergency Department
	Discharge Planning for Homeless Patients
	ED: Initiation of Buprenorphine in the Emergency Department
	Emergency Department Level of Care Assessment
	Emergency Department Telephone Advice Information
	Emergency Medical Screening of Patients on Hospital Property
	Emergency Medication and Code Blue Crash Cart Policy
	Emergency Medication Trays Policy
	Emergency Room Overcrowding
	EMTALA Policy

Page 2 of 4 (78 items) 1 2 3 4

Type	Title
	Entering an ED Admission (observation, surgery, inpatient status) into Health Information System
	Evaluation and Medical Screening of Patients Presenting to the Emergency Department
	Evaluation of Pregnant Patients in the Emergency Department
	Handling of Infants/Fetus/Stillborns and Genetic Workup
	In-House Transport of Ventilator Dependent Patients
	Interfacility Transfer Guidelines
	Intubation Tray Adult/Pediatric
	Intubation Tray Infant
	Iron Dextran (Imferon) Administration
	Latex Precautions
	Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer
	Legal Blood Alcohol Intake Form Completion of the
	Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement
	Medication Reconciliation
	Medications Emergency Department
	Mentally Ill Patients Detention of
	MICN Guidelines
	Myocardial Perfusion Stress Test: Nuclear
	Neupogen / Procrit Administration
	NPO Guidelines

Page 3 of 4 (78 items) « < 1 2 3 4 > »

Type	Title
	Nursing Care of Outpatient Interventional Radiology Patient
	Nutritional IV
	OmniCell Automated Dispensing Unit (ADU)
	Oxygen Therapy
	Pap Smear Specimen Handling and Collections
	PAPR Respirator Inspection Record
	Patient Valuables and Personal Effects in the Emergency Room
	Patient Warmer (Warm Air Hyperthermia System)
	Patients Under the Influence of Drugs Management of
	Pediatric Order Verificaton Overnight
	Pentax Emergency Bedside Intubating Laryngoscope
	Photo Documentation Policy
	Physician Orders Thrombolytic Therapy for Acute Ischemic Stroke with Alteplase
	Physician Request for Consult
	Poison and Drug Overdose Information
	Portacath Vascular Access System
	Potassium Intravenous Administration
	Pregnancy Loss Specimens
	Pre-Hospital Care Policy
	Propofol Use In Critical Care Areas

Page 4 of 4 (78 items) « < 1 2 3 4 > »

Type	Title
	Quality Assurance Review Daily Chart Review
	Quality Improvement Program Pre-Hospital
	Quality Management Program Emergency Service
	Radiation Policy for Management of Patients with Excessive Exposure
	Recommendation for Prophylaxis After Occupational Exposure to HIV
	Removal of Placenta from Hospital per Patient's Request
	Responding to Ventilator, BiPAP, Vapotherm, EtCO2 and SpO2 Alarms
	Resuscitation Quality Improvement (RQI)
	Safely Surrendered Baby Policy and Procedure
	Saline Lock For Blood Draw
	Scope of Service for the Emergency Department
	Sexual Assault Exam Policy*
	Standardized Procedures for Medical Functions in the Emergency Department
	Thrombolytic Therapy Focus Review
	Thrombolytic Therapy for Acute Myocardial Infarction
	Transfer of Evidence
	Trauma Patient Care in the Emergency Department
	Warming Cabinet for Blankets/Solutions

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Bite Guidelines, Animals	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Dept. Manager	Effective Date: 04/1992

PURPOSE:
The primary role of the Emergency Department in preventing rabies is in accurately reporting to the County Health Department and Animal Control and to provide proper acute wound management.

POLICY AND TREATMENT GUIDELINES:

A. All "at risk" wounds should be thoroughly cleansed with antibacterial soap and water, sutured by physician as needed and covered with dressing.
B. Tetanus immunization should be updated as needed.
C. All animal bites, including family's own pet must be reported to:

1. Inyo County Animal Control
   a. Monday- Friday 8 AM- 5 PM (760) 873-7852
   b. Weekends and after 5 PM
      -Inyo County Sheriff (760) 873-7887
2. Mono County Sheriff's Department (760) 932- 7549

D. If local health officials cannot provide information, call
   1. California State Department of Health (415) 540-2000

E . Rabies Prophylaxis:

1. Animal not able to be captured:
   a. If high risk species (raccoon, bat, skunk, coyotes, etc.)

   - Treat with Rabies Immune Globulin (RIG) per American Hospital Formulary Service (AHFS) recommendations.
     - Dose infiltrated into wound should be performed by physician.
   - Also treat with Human Diploid Cell Rabies Vaccine (HDCV) per AHFS recommendations.
   - Vaccine is available in the NIHD pharmacy.
   - Antibiotics as needed per emergency room physician
   - Advise to follow up at Inyo County Health Department.

   b. Low risk species (dog, cat, rabbit, rodents, birds)

   - Consult with local animal control officer as to presence of rabies in species.
   - Consider treatment if animal attack was bizarre, abnormal, or totally unprovoked.

2. If animal captured: (Follow treatment according to Animal Control guidelines)
   a. If high risk animal or abnormal behavior - start treatment unless animal test is done immediately. (This normally takes 2-3 days).

   - If positive, start above treatment protocols.

Title: Bite Guidelines, Animals	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Dept. Manager	Effective Date: 04/1992

- If negative, do not treat.

DOCUMENTATION:
1. Note on medical record when Animal Control was contacted.
2. Document discharge instructions on wound care and any needed follow up with Animal Control and primary physician.

REFERENCE:
Inyo County Animal Control Rabies Policy

CROSSREFERENCE:

Approval	**Date**
CCOC	1/29/18
Emergency Services Committee	3/14/18
MEC	4/3/18
Board of Directors	4/18/18
Last Board of Director Review	6/19/19

Developed: 4/92
Revised: 3/98, 03/09/04 MR
Reviewed: 08/2010as; 09/2012as, 1/18 gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Code Blue (Cardiac Arrest) Documentation**	
Scope: Hospital Wide	Department: **Emergency Dept.**
Source: Emergency Department Manager	Effective Date: 2/22/18

PURPOSE:
1. To ensure that Code Blue resuscitation is documented in a consistent manner throughout the hospital.
2. To provide a record of care delivered during resuscitation.
3. To serve as verification for reimbursement.

POLICY:
1. The *Northern Inyo Hospital Resuscitation Record* will be used for documentation during cardiac, respiratory or other code blue resuscitation for all adults. The *Neonatal Code Blue Sheet* will be used for neonatal resuscitations.
2. Any cardiac arrest in the operating room will follow the Cardiac Arrest in OR Policy and will use either the *Northern Inyo Resuscitation Record* or the *Neonatal Code Blue Sheet* for documentation, as appropriate.
3. Respiratory Therapy shall record their activity and observations in the patient's electronic health record.
4. The Code IV RN has responsibility for the documentation done during the resuscitation event, and must review with the Code I RN completeness of documentation and co-sign the *Northern Inyo Hospital Resuscitation Record* document.

PROCEDURE:
1. Sticker or write the patient's name on all forms used for documentation.
2. Date all forms.
3. Chart the specific time of the entry or specific time each event took place when documenting on the Resuscitation document.
4. Number ALL pages of the resuscitation record in consecutive order beginning with page one and filling in the TOTAL number of all pages. Include all supporting narrative pages and supportive monitor strips. Example: Page 1 of 6
5. Write on lines provided and draw a line through any unused spaces or pages. Note "N/A" in spaces on the record where information is not applicable.
6. Record and post rhythm strips of all events of resuscitation- initial rhythm, post defibrillation, post resuscitation medication, any change in rhythm and termination of resuscitation.

DOCUMENTATION:

A. Page 1 of document
1. Document time of arrest and place of arrest. (Med-Surg, ICU, private residence, etc.)
2. Document, if appropriate, if brought in by EMS and what type (BLS, ALS) and estimated pre-hospital downtime.
3. Document all other ancillary departments called and arrival time to unit.
4. Document all procedures initiated by EMS on field or initiated by Code Blue team on unit. (e.g. Endotracheal tube ETT, Intraosseous IO, Nasogastric or Orogastric tube NGT/OGT , Foley Catheter, etc.) Include sizes of tubes, site, drainage, etc.
5. Document under *Notes* patient assessment on initiation of Code Blue and other narrative documentation.
6. Obtain signatures of all members of Code Team including responding physicians and ancillary departments.
7. Document, if appropriate, when resuscitation efforts were discontinued and pronouncing physician
8. Document disposition of patient if transferred to other facility or unit.

Title: **Code Blue (Cardiac Arrest) Documentation**	
Scope: Hospital Wide	Department: **Emergency Dept.**
Source: Emergency Department Manager	Effective Date: 2/22/18

B. Page 2 of document

1. Document initial vital signs on arrival of EMS or Code Blue team.
2. Document Initial Assessment according to determined systems.
3. Obtain signatures of staff performing assessments.

C. Page 3 of document

1. Document in appropriate columns: time, MAP/temperature, HR/ rhythm, defibrillation joules, O2/ SpO2, ETCO2, medications administered with dosage and route and initials of staff administering medication, GCS/LOC.
2. Document under *Notes* other documentation for procedures and other assessments.(CPR in progress, CPR stopped, Portable Chest X-ray, bloods drawn, etc.)
3. Obtain signatures of staff administering medications, performing procedures or involved in continuing resuscitation.

D. Page 4 of document.

1. Document repeat assessments according to systems. If no change in patient status " no change" may be written.
2. Document any other narrative documentation.

CROSS REFERENCE P&P:

1. Rapid Response Team
2. Code Blue procedure- Code Blue Team
3. Cardiac Arrest in the Operating Room

Approval	**Date**
CCOC	11/6/17
Emergency Services Committee	1/10/18
Resuscitation Committee	12/6/2017
Medical services/ ICU Committee	1/25/18
Perinatal/Pediatrics Committee	12/15/17
Surgery/Tissue Committee	1/24/18
Medical Executive Committee	2/6/17
Board of Directors	2/21/18
Last Board of Director's Review	6/19/19

Revised: 11/2017

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Communicable Disease Prevention Of Pre Hospital Care Worker**	
Scope:	Department: **Emergency Dept**
Source: Director of Quality and Infection Prevention	Effective Date: 04/95

PURPOSE:

Section 1797.188 of the Health and Safety Code requires County Health officers to notify pre-hospital care workers of their exposure to a person with a reportable disease which can be spread through oral contact, secretions of the body and blood – effective January, 1987, and as per Ryan White Act Law 101-381, 1994.

This policy will insure that the emergency room at Northern Inyo Hospital has a system for notifying the Inyo County health officer of these exposures, by notifying the designated officer (Infection Control Practitioner).

PROCEDURE:

I. If the pre-hospital care worker feels that he/she has been exposed to significant bodily secretions (saliva, blood, etc.) from a patient, he/she must provide the NIH Emergency Department with his/her address, telephone number and the patients name using the "document of exposure form".

II. The Infection Control Practitioner or Employee Health Nurse (the designated officers) will report to the Emergency Department Nurse Managager, the names of patients seen in the Emergency Department who have positive laboratory tests for communicable diseases.

III. The Emergency Department or Infection Control Practitioner will provide the Health Department with information about pre-hospital care workers exposed to patients with a communicable disease, as per County Health Department Policy. The designated officer will do follow up care as indicated.

Committee(s) approval needed: No
Responsibility for review and maintenance: Emergency Department Manager
Index Listings: Pre-Hospital Careworker – Disease Prevention
Revised: 4/95; 4/2000, 2/01, 2/05AS, 2/07AS, 2/09AS, 6/11AS
Last Board of Director review: 7/18/18; 6/19/19

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Computer Downtime Emergency Department**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date: 4/04

PURPOSE: To provide a format for functioning of the Emergency Department in relation to the Logicare System when the total computer system is not available.

POLICY: If a computer problem jeopardizes the delivery of patient care and there is not staff available to troubleshoot and correct the problem, the Nursing Supervisor will contact the on call **I.T.** person.

SPECIAL CONSIDERATIONS: Delivery of safe and effective patient care will always be the prime concern. Keeping in mind that complete discharge instructions is a large portion of proper patient care.

EQUIPMENT:

1. Alternate Discharge Instruction form found in the bottom center file drawer in the ER Office. English and Spanish versions are available.
2. Copies of specific Topics are available in ring binders in the ER Office. (On top of the lockers.)

PROCEDURE:

1. Alternate Discharge Instructions will be obtained and patient identification will be placed on the form. The form will be filled out and given to the patient after it is accompanied by the appropriate Topic pages. Copies will be made of all pages after they are signed by the patient or responsible party. The original will be given to the patient and the copy will be retained in the chart. Alternate Learning Needs Assessments will also be obtained and appropriately identified. When completed it will be placed with the chart.
2. When the computer system has been restored to working order. Measures need to be taken to make sure the data regarding visits during the time the computer was down is added (i.e. visits, dates, times, Illnesses, Medications, etc.)

DOCUMENTATION:

The copies of Discharge Instructions and accompanying topics will serve as documentation.

Committee approval needed: _X_ no, ___ yes
Responsibility for review and maintenance: ER Nurse Manager
Index Listings: ER Computer Down Time; Computer Down Time, ER;

Revised	4/2/2004
Reviewed	6/11as; 2/15as
Last Board of Director review:	6/19/19

ARCHIVED

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Computer Interface Down Time Emergency Department**	
Scope:	Department: **Emergency Dept**
Source: Andrew Stevens	Effective Date: 4/04

PURPOSE: To provide a format for functioning of the Emergency Department in relation to the Logicare System when the interface between the Affinity Registration System is not available.

POLICY: If a computer problem jeopardizes the delivery of patient care and there is not staff available to troubleshoot and correct the problem, the Nursing Supervisor will contact the on call **I.T.** person.

SPECIAL CONSIDERATIONS: Delivery of safe and effective patient care will always be the prime concern. Keeping in mind that complete discharge instructions is a large portion of proper patient care.

PROCEDURE:

1. Patients may be registered according to the Sign-In Procedure found in the Computer Manual. Make sure that the date and time of registration entered are the same as those reflected on the chart.
2. All other functions of the Logicare System can then proceed as usual until after the Interface connection is restored.
3. Once the Interface is restored all patients entered during the time the connection has been lost will appear on the Status Board. To Insure integrity of the database, the information provided by the interface needs to be moved to the hand registered visit according to the Moving Information Procedure in the Computer Manual.

DOCUMENTATION:

Committee approval needed: _X_ no, ___ yes
Responsibility for review and maintenance: Emergency Nurse Manager
Index Listings: ER Computer Interface Down Time; Logicare Interface Down Time; Down Time: Computer, Logicare Interface; Interface Down Time, Logicare

Revised	4/2/2004
Reviewed	6/11as; 2/15as
Board of Directors Review:	6/19/19

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Consent for Medical Treatment**	
Scope:	Department: **Emergency Dept, Medical Staff, Rural Health Clinic**
Source: Emergency Dept Nurse Manager	Effective Date: 03/1995

POLICY:
Valid consent to treatment must be obtained in all cases. The law is clear on what constitutes valid consent. However, complex laws regulate unusual instances. In general, it is better to err on the side of treatment than non-treatment. Most suits originate from the refusal of service or improper treatment, rather than treating without consent. Every effort must be made to obtain written consent from the legally responsible party. If this is totally impossible, it should be fully documented and recorded in the chart, listing the times and the phone calls, etc. that were made in an effort to obtain consent. Service should never be refused. The hospital has no legal right to refuse treatment for any reason.

DEFINITIONS:

Expressed consent:
The patient verbally expresses to the practitioner that he consents to treatment.

Implied consent:
There are no expressed words of consent but the actions of the patient are sufficient to imply to any reasonable person that the patient has consented to treatment or would consent if he were able, e.g., the unconscious patient whose mere presence in the Emergency Room implies consent. ***It is not known that he would refuse if able to express choices.***

Informed consent:
The patient must be competent and legally responsible to give consent and must understand the risks and benefits inherent in the proposed procedure. If damages occur and there is no informed consent, the health practitioner is liable for battery and responsible for all resulting damages without the patient having to prove negligence. (See "Informed Consent Policy - Physician's Responsibility, page).

PROCEDURE:

Necessary Consents:
(For further information refer to consent manual)
Treatment in the Emergency Department
Conditions of Admission - if patient admitted
Examination in the cases of alleged sexual assault and the collection of evidence
Photographs
Surgical or specific diagnostic treatment
Release of information to the press (other than specified in "Release of Information" procedure
Assignment of financial responsibility

Title: **Consent for Medical Treatment**	
Scope:	Department: **Emergency Dept, Medical Staff, Rural Health Clinic**
Source: Emergency Dept Nurse Manager	Effective Date: 03/1995

(PROCEDURE continued:)

Conditional or Circumstantial Consents:
Miscarriage or Partial Abortion Form (may be advised)
Administration of blood
Drawing of blood alcohol
Leaving Hospital Against Medical Advice
Sterilization
Permission for Disposal of Severed Member

ADULTS:

1. All **competent** adults, regardless of sex or marital status, sign their own consents for medical and surgical treatment. This is true even if the patient cannot sign a consent form.
2. Verbal consent is valid when written consent cannot be obtained, such as when the patient is unable to write. Verbal consent is given in the presence of witnesses and recorded.
3. A husband or wife may not authorize surgery and/or treatment for the spouse without the consent of the patient, except in cases of mental incompetence or life-threatening emergency.
4. Incompetent adults must have some competent person or person having Advance Health Care Directive or Durable Power of Attorney for Health Care, legal ***guardian or nearest of kin***, sign for them. The attending physician may take responsibility in emergency cases or where other ***consents*** are unobtainable. Document circumstances in chart.

TELEPHONE CONSENT

Telephone consents may be recorded on the recorder in the **ER *admitting area.***

CONSENT FROM PRE-MEDICATED PATIENT

If surgery is to be performed on a patient who has already received medication, the doctor must explain the anticipated procedure and obtain the consent signature himself. It is not necessary to have the consent form typed out; it may be handwritten, ready to be signed by the patient.

LIFE-THREATENING EMERGENCIES

The doctor may treat an adult or child if the consent cannot be obtained immediately. The physician must write a statement to the effect that this is an extreme emergency ***where treatment appears immediately required and necessary to alleviate severe pain or to immediately diagnose and treat a condition that would lead to severe disability or death if not diagnosed or treated immediately. There must also be no evidence that the patient (or guardian) would object to the treatment if able to consent (i.e. known Jehovah Witness).*** Attempts to reach next of kin should be documented. This is covered under the law of implied consent.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Consent for Medical Treatment**	
Scope:	Department: **Emergency Dept, Medical Staff, Rural Health Clinic**
Source: Emergency Dept Nurse Manager	Effective Date: 03/1995

MINORS

Only parents or legal guardians may sign for minors living at home under most circumstances. (see Appendix A). Brother, sister, aunt, etc. may not sign unless they are the legal guardian. In some cases, as when minor is in camp or staying with neighbors, etc., a note giving permission to seek treatment signed by both parents, ***or person with legal custody of child,*** may be presented to the Emergency Room. This is usually sufficient to treat; however, if the illness or injury is severe, every effort must be made to contact the parents, or act as explained above. Some minors have right to consent under other circumstances also. See Appendix A.

In Cases Of Children Placed for Adoption or in a Foster Home:

1. Children Placed for Adoption: the agency has the right to consent.

2. Children in Independent or Private Placement: the adopting parent may not have the right to consent and may not be able to find the real mother. In this case, except for emergency, a court order is required. ***Often this permission is provided by birth parent on State Form AD-22. Note: Must see form.***

3. Children Placed in Foster Homes Under Legal Custody of an Agency: the agency, not the foster parents, has the right to consent. ***The foster parents may be authorized by agency to grant permission. This permission must be verified.***

4. Words of the Court: Court gives the form to each foster parent or case worker indicating authorization for treatment.
   See Appendix A for further guidelines/form

5. Child Living with non-parent adult relative: Effective June 6, 1994, a non-parent adult relative with whom a minor is living may authorize medical care for the minor by signing a Caregiver's Authorization Affidavit.

   SB 592 (Stats. 1994, Chapter 98) authored by Senator Newton Russell, adds sections 6550 and 6552 to the Family Code, and sets forth the circumstances under which an adult relative who is not the parent, legal guardian, or conservator of a minor, may provide consent for medical treatment of the minor. The new law does not specify the range of medical treatment for which consent may be provided, however, it does require that the relative attempt to consult with the parent(s) and receive no objection to the proposed treatment. All of the following must apply in order for the authorization to be valid:

   1. The minor must be living with the adult family member.
   2. The adult must be a "qualified relative," which is defined in the law as a spouse, parent, stepparent, brother, sister, stepsister, half-brother, half-sister, uncle, aunt, niece, nephew, first cousin or any person denoted by the prefix "grand" or "great" or the spouse of any of the persons specified in this definition, even after the marriage has been terminated by death or dissolution.

Title: **Consent for Medical Treatment**	
Scope:	Department: **Emergency Dept, Medical Staff, Rural Health Clinic**
Source: Emergency Dept Nurse Manager	Effective Date: 03/1995

3. The adult must advise the parents of the proposed medical treatment and have received no objection thereto; or the adult must be unable to contact the parents.
4. The adult must complete an affidavit (see attached) in which he or she attests that the elements outlined above are true and correct. Hospitals may use the CAHHS model affidavit or develop their own document, so long as it includes all of the elements and highlights as provided in the CAHHS form. The Department of Health Services will not develop an official form
5. The affidavit is valid for only one year from the date of the signature.

Health care providers who treat minors in reliance on the signed affidavit of a qualified relative are given certain protections from liability in the new law. Sections 6550(d) and (e) provide:

d. No person who acts in good faith reliance on a caregiver's authorization affidavit to provide medical or dental care, without actual knowledge of facts contrary to those stated on the affidavit, is subject to criminal liability or civil liability to any person, or is subject to professional disciplinary action, for such reliance if the applicable portions of the affidavit are completed.

e. A person who relies on the affidavit has no obligation to make any further inquiry or investigation.

Healthcare providers should be careful to require that the affidavit is completed in its entirety, and that an attempt has been made to reach the minor's parents, prior to care being delivered to the minor.

See Appendix B for forms.

See California Hospital Association's Consent Manual for any further questions. It is located in the Emergency Room and/or in Social Worker's office.

Reference: SB 592, 6550-6552 (1994, Chapter 98) - minors
Committee approval needed: No
Responsibility for review and maintenance: Emergency Room Head Nurse
Index Listings: Consent for Treatment: Medical Consent; Medical Consent; Consent, Self sufficient minors; Minor Consent for Treatment; Consent, Legal Requirements
Revised: 3/95; 2/00, 09/11as
Last Board of Director review: 7/18/18; 6/19/19

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Consent for Medical Treatment**	
Scope:	Department: **Emergency Dept, Medical Staff, Rural Health Clinic**
Source: Emergency Dept Nurse Manager	Effective Date: 03/1995

EDNORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Coroner's Cases**	
Scope: Multi- Department	Department: ED, Perinatal, Surgery, ICU, Med Surg
Source: Emergency Department Manager	Effective Date: 04/86

PURPOSE: To provide a procedure for establishing, reporting and preparing coroner's cases.

POLICY:
All deaths in the hospital are reported to the House Supervisor (HS) . The HS calls the coroner about the death that falls under the classification of reportable cases. In no instance should a body under the jurisdiction of the Coroner be released to a funeral establishment, or removed from surgery or emergency room except by explicit instructions from the Coroner's office. Permission from the deceased's family for autopsy is desirable but not mandatory. The Coroner is entitled to the custody of the remains until the conclusion of his autopsy or medical investigation.

TYPE OF CONORER'S CASES:

1. No physician in attendance at the time of death.
   a. If the physician has not seen the patient during the 20 days before death.
   b. If the physician has been in attendance less than 24 hours, or when attending physician is unable to make the diagnosis.
2. Known or suspected homicide.
3. Known or suspected suicide.
4. Involving any criminal action or suspicion of a criminal act, such as criminal abortion or euthanasia.
5. Related or following known or suspected self-induced criminal abortion.
6. Associated with a known or alleged rape or abnormal sex act.
7. Following an accident or injury (primary or contributory) occurring recently or at some remote time.
8. Drowning, fire, hanging, gunshot, stabbing, cutting, starvation, exposure, acute alcoholism, drug addiction, strangulation or aspiration.
9. Accidental poisoning (food, chemical, drug, therapeutic agent).
10. Occupational diseases or occupational hazards.
11. Known or suspected contagious disease constituting a public hazard.
12. All deaths in an operating room.
13. All deaths where a patient has not recovered from an anesthetic, whether in surgery, recovery room or elsewhere.
14. All deaths in which the patient is comatose throughout the period of physician's attendance, whether at home or in the hospital.
15. Deaths of patients in state mental hospitals serving the mentally disabled and developmentally disabled operated by State Agencies.
16. Deaths wherein suspected cause is Sudden Infant Death Syndrome.
17. In prison or while under sentence.
18. All solitary death unattended by physician or other person in period preceding death.
19. All deaths of unidentified persons.

Title: **Coroner's Cases**	
Scope: Multi- Department	Department: ED, Perinatal, Surgery, ICU, Med Surg
Source: Emergency Department Manager	Effective Date: 04/86

20. Deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by a criminal act.

PROCEDURE:

1. Notify the House Supervisor of all patient deaths. The HS can call the coroner at (760) 873-4266 to notify of death. If you have doubt, or not sure if the cause should be a coroner's case, call the coroner and ask.
2. Do not remove any tubes (example: ET, IV, Foley, Chest Tubes, etc.). Simply clamp off the ones that may drain.
3. Do not clean the body (example: it could remove powder burns or other forms of evidence).
4. Wait for the coroner to pick up the body.
5. The coroner will complete the "Authorization for Release of Body to Mortuary" form. This completed form is then part of the medical record.
6. The patient's belongings are given to the coroner. Do not release any evidence or personal property to law enforcement or family without the knowledge and consent of coroner.

DOCUMENTATION:

1. Document in medical record:
   a. All documentation regarding the patient's death.
   b. Time of death according to physician pronouncement.
   c. Family members notified.
   d. Time coroner picked up the body.
   e. Tubes left in place.
   f. Any belongings sent with the body or home with the family. The clothing may be given to the family only with the permission and in the presence of the coroner

REFERENCE:

1. California Public Law. Health and Safety Code (2010). Article 3. *Responsibility of Coroner.* Section 102850-10286
2. Center for Disease Control and Prevention. Coroner/Medical Examiner Laws. Retrieved from http//www.cdc.gov/phlp/publications/coroner/california.html.
3. California Code, Government Code Section 27491.Retrieved from https://codes.findlaw.com/ca/government-code/gov-sect-27491.html

CROSS REFERENCE:

1. Neonatal Death, Fetal Demise & Spontaneous Abortion Procedure
2. Death- Disposition of Body
3. Death in the Operating Room
4. Pronouncement of Death.
5. Dead on Arrival

EDNORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

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CROSS REFERENCE:

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EDNORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Coroner's Cases**	
Scope: Multi- Department	Department: ED, Perinatal, Surgery, ICU, Med Surg
Source: Emergency Department Manager	Effective Date: 04/86

Approval	Date
CCOC	5/21/18
Emergency Services Committee	7/11/18
Med/ICU Committee	7/26/18
Peri-Peds Committee	6/22/18
Surgery-Tissue Committee	7/25/18
Medical Executive Committee	8/7/18
Board of Directors	8/15/18
Last Board of Director Review	2/18/2020

Revised/Reviewed: 4/86, 7/91, 2/95, 11/99, 03/09/04 MR; 7/11as; 2/15as, 4/18 gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Dead on Arrival*	
Scope: Departmental	Department: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 10/04/06

PURPOSE:
To provide the Emergency Department staff with current guidelines for managing patients dead on arrival. Dead on arrival being defined as a patient brought to the Emergency Department who is dead and for whom any resuscitation efforts would be futile.

POLICY:
Pre-hospital providers and law enforcement agencies who cannot determine death in the field, will bring patients to the Emergency Room to be pronounced legally dead by a physician. Please note that when death can be determined in the field by an agency, i.e., ALS/Paramedic, the coroner is then contacted to legally pronounce the patient. Penal Code does not allow any agency to transport directly to the morgue to be pronounced.

PROCEDURE:
1. The physician in the Emergency Room will examine the body.
2. The deceased should be placed in an unoccupied room, if possible.
3. Family members should be shown to the waiting room or a quiet area.
4. The physician should speak with the family as soon as possible.
5. Forms to be completed after pronouncement of the patient:
    a. An Emergency Room Department record.
    b. Release of Body to Mortuary.
    c. Organ Procurement Notification.
6. Authorities to be notified:
    a. If an accident or suicide, notify appropriate law enforcement agency.
    b. If a coroner's case, notify the coroner.
    c. Notify Nursing Supervisor.

CORONER CASES:
1. Clothing, personal effects or valuables should not be removed before coroner arrives. Items already removed should be placed in a bag, labeled and given to the coroner. Personal effects should not be given to the family until released by the coroner.
2. If the coroner orders an autopsy, family permission is not necessary.
3. If the family has no preference or there is no family, the coroner should specify to which mortuary the body would be removed.
4. Coroner should notify family of death if this has not already been done.
5. Coroner is responsible for identifying unknown D.O.A. He may authorize hospital to assist in this identification.

NON-CORONER CASES:
1. Mortuary
    a. The relatives should specify agent for disposal of body.
    b. If no relatives, coroner to specify mortuary.
    c. Emergency Room staff should call the appropriate mortuary after determination by coroner or relative.
2. Valuables
    a. Relatives sign for possessions.

Title: Dead on Arrival*	
Scope: Departmental	Department: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 10/04/06

b. If no relatives, valuable are placed in safekeeping.
3. If an autopsy is to be performed, a family member must sign authorization.
4. Agency picking up the body must sign "Release of Body to Mortuary".

NURSING RESPONSIBILITIES:

1. If possible, a nurse should accompany doctor when he notifies family.
2. Ask family if they wish assistance, i.e. minister, priest, friend.
3. Provide emotional support.
4. Where appropriate, arrange for community support follow-up for relatives, i.e., social worker, psychiatric help.

DOCUMENTATION:

Release of patient information.
Organ donation policy.

Approval	Date
CCOC	4/24/2017
Emergency Services	5/18/17
Medical Executive Committee	6/6/17
Board of Directors	6/21/17
Last Board of Director review	6/19/19

Initiated: 4/92
Reviewed: 4/17kp
Revised: 03/2000; 02/02, 03/05, 02/08 AS, 08/11 AS
Index Listings: DOA – Dead on Arrival; Coroner's Case: Deceased Patients – ER Policy

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: **Dental Emergencies in the Emergency Department**	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Department Manager	Effective Date: 12/2018

PURPOSE:
To establish appropriate guidelines for utilization of on-call Dental Staff in the Emergency Department (ED)

POLICY:
On-call Dental Staff are to be utilized only for dental emergencies requiring immediate intervention.

PROCEDURE:
1. The Dental Physician on-call will be contacted when the need for emergent dental care has been determined by the ER Physician.
    a. House Supervisor must be notified of any emergent surgical procedures to be performed within the facility.
2. A list of local area dentist can be provided to patients who have no local dentist for follow-up.

REFERENCES:
1. EMTALA: A Guide to Patient Anti -Dumping Laws. (2009)

CROSS REFERENCE P&P:
1. EMTALA Policy
2. Evaluation and Screening of Patients Presenting to Emergency Department.

Approval	**Date**
CCOC	1/29/18
Emergency Services committee	11/7/18
Medical Executive Committee	12/4/18
Board of Directors	6/21/17
Last Board of Directors Review	6/19/19

Developed: 1/2018gr
Reviewed:
Revised:
Supersedes: Dental Emergency Protocol

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Disaster Management Committee	
Scope: District Wide	Manual: Emergency Dept
Source: Manager, Emergency Department/ Disaster Planning	Effective Date: 12/19/19

PURPOSE:
The committee's mission is to collaborate on emergency management strategies and initiatives designed to enhance preparedness and improve Northern Inyo Healthcare District's (NIHD) ability to respond to, and recover from, all threats.

SCOPE OF AUTHORITY:
The purview of the Committee is limited to matters that pertain to the Emergency Operation Plan's mitigation, preparedness, response and recovery strategies

REPORTING STRUCTURE:
The Committee reports to the Emergency Services Committee.

MEMBERSHIP:
The following departments will be represented in the Disaster Management Committee:

- Manager, Emergency Department & Disaster Planning
- Assistant Manager, Emergency Department & Disaster Planning
- Chief Operations Officer
- Director, Emergency Department & Inpatient Services
- Medical Director, Emergency Department (or designee)
- Manager, ICU/ Acute-Subacute
- House Supervisor
- Director, Perioperative Services
- Director, Safety
- Director, Diagnostic Services
- Controller, Finance Department
- Manager, Information Technology Services (ITS)
- Administrative Staff Director, Northern Inyo Associates/ Rural Health Clinic (NIA/RHC)
- Manager, Plant Operations
- Director, Purchasing
- Director, Pharmacy
- Director, Environmental Services and Laundry
- Manager, Infection Prevention/ Clinical Informatics
- Director, Dietary
- Additional consultants (i.e. legal, compliance, consultants) can be invited to assist when needed.

RESPONSIBILITIES:
The committee is responsible for:

- Continuously analyzing all risks which expose NIHD to the potential disruption of its activities, including risks that are natural and manmade.

Title: Disaster Management Committee	
Scope: District Wide	Manual: Emergency Dept
Source: Manager, Emergency Department/ Disaster Planning	Effective Date: 12/19/19

- Overseeing the development of emergency preparedness and response plans in response to the risks and hazards identified.
- Presenting district wide emergency response plans to the Board of Directors for approval and further presentation to the Executive Group for approval to implement.
- Assisting with the development of emergency response plans for departments and units, and for ensuring they align with the district wide plan.
- Facilitating communication of the emergency operations plan through updates in the NIHD website and written materials as needed.
- Designing and conducting two internal disaster drills per year, with one of the drills to include a surge event and another to include participation with external emergency response agencies.
- Developing training materials and facilitating the appropriate training for the district employees.
- Annual review of existing emergency management plans and related policies and procedures.
- Recording meeting minutes, After Action Reports (AAR), Healthcare Coalition (HCC) meeting minutes and distributing them to its members.

MEETINGS:
The committee will meet at least quarterly and more often as needed . A majority of the committee members shall constitute a quorum. The committee chair will keep a copy of the committee meeting minutes and forward a copy to the Executive Team.

REFERENCE:
1. California Hospital Association. Emergency Preparedness- Preparing Hospitals for Disaster. https://www.calhospitalprepare.org/emergency-operations-plan
2. The Joint Commission- Emergency Management in Healthcare, An All-Hazards Approach. 2008. https://www.jointcommission.org/emergency_management.aspx
3. Centers for Medicare and Medicaid Services (CMS). *Emergency Preparedness Rule.* https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertEmergPrep/Emergency-Prep-Rule.html

CROSS REFERENCE P&P:
1. Emergency Management Plan

Approval	**Date**
Disaster Management Committee	10//2019
Emergency Services Committee	11/13/19
Medical Executive Committee	12/03/19
Board of Directors	12/18/19
Last Board of Directors Review	12/18/19

Developed: 09/2019 gr
Reviewed:
Revised:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Discharge Instructions Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 5/1/18

PURPOSE:
To ensure that all patients discharged from the Emergency Department (ED) have thorough, appropriate and consistent discharge instruction and directions for follow-up care.

POLICY:
Discharge instructions are mandatory for all patients discharged from the Emergency Department. These instructions will be in a typed written format utilizing the Computerized Discharge Instruction System. The generated discharge instructions will be verbally reviewed with the patient or responsible party and the patient or responsible party will sign a copy of same indicating that the nurse has reviewed the instructions with them and that any questions have been answered. The patient will be referred to their own or other physician as appropriate for follow-up care, or may return to the Emergency Department if needed.

All topics will be reviewed and approved by the Chief of Emergency Services or Designee before being entered into the Discharge Instruction Computer database.

EQUIPMENT:
Discharge instructions can be generated from the computers located in the Main Room of the Emergency Department, the ER Office, and in the ER Nurse Managers Office using the Computerized Discharge Instructions System.

PROCEDURE:
1. The ED Physician will write his/her discharge instructions in the template, the first page of the ED chart, or in their dictated note.
2. Discharge instructions for each patient will be generated from the Computerized Discharge Instructions Systems.
3. database as directed by the Physician utilizing topics in Illnesses; Medications; Follow-Up; Activity Limitations; Devices, Equipment and Treatment; Diets; Dressings, Drains and Wound Care; Lifestyle and Environment; Procedures, Tests and Preps; and Health and Wellness Promotions.
4. The instructions will be reviewed with the patient and/or responsible party by a Registered Nurse. All questions will be addressed and a signature will be obtained indicating that all questions have been answered. The original discharge instructions will be given to the patient, family or responsible party. The copy will become part of the Medical Record after being signed and timed by the Registered Nurse.
5. Any special instructions such as School or Work Releases will be created if needed and a copy of same will be retained in the Medical Record.
6. Discharge instructions can be printed in Spanish during the printing process.

DOCUMENTATION:
In addition to signing the discharge instructions provided to the patient, a note will be made in the narrative record addressing the patient discharge by the nurse.

REFERENCES:

1. Emergency Nurses Association. (2017). Safe Discharge From the Emergency Setting Position Statement. Retrieved from https://www.ena.org/docs/default-source/resource-library/practice-resources/position-statements/safedischargefromed.pdf?sfvrsn=998ee45f_6

CROSS REFERENCE P&P:
1. Standards of Care in the Emergency Department

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Discharge Instructions Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 5/1/18

Committee Approval	**Date**
Clinical Consistency Committee	1/29/18
Emergency Services Committee	3/14/18
Medical Executive Committee	4/3/18
Board of Directors	4/18/18
Last Board of Director review	6/19/19

Reviewed: 12/15as
Revised: 12/17gr

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Discharge Planning for Homeless Patients	
Scope: Emergency Department & Inpatient Services	Manual: Admissions Services, Case Management, Dietary, Emergency Dept, ICU/CCU, Medical/Surgical, Nursing Administration, Perinatal, Social Services
Source: Chief Nursing Officer	Effective Date: 1/17/19

PURPOSE:
To help NIHD staff understand the law on preparing to return homeless patients to the community.

POLICY:
1. Transitional care (discharge planning) for homeless patients will align with the Discharge Planning for the Hospitalized Patient policy, beginning upon admission to inpatient.
2. Homeless patients in the Emergency Department (ED) will receive additional services to meet their unique needs as outlined in procedure below.

DEFINITION:
1. Homeless patient – an individual who:
   a. Lacks a fixed and regular nighttime residence, or
   b. Has a primary nighttime residence that is a supervised operated shelter, or
   c. Is residing in a public or private place not designed to be used as a sleeping accommodation.
2. Residence – the location identified to the hospital by the homeless patient as his/her principal dwelling place.

PROCEDURE:
1. Determination of housing status
   a. Lack of housing must not be used to discriminate against a homeless patient.
   b. Discharge planning must include inquiry about housing status for all ED and Inpatients. This must be documented in the patient's medical record.
2. Discharge planning must be individualized for each homeless patient and must be provided in a culturally competent manner; including use of a language that the patient understands.
   a. Must be guided by the best interests of the homeless patient
   b. Must include plans to address physical and mental conditions
3. The homeless patient has the right to refuse District plans or services offered to support discharge planning.
4. The District will work with the patient to identify a post-discharge destination. Currently no homeless shelters exist within the County of Inyo.
   a. Attempts will be made to determine current 'residence' of the patient
   b. Documentation of alternative destination choice by the patient will be made by nursing or case management staff when the patient so chooses.
   c. Homeless patients may not be sent out of county, per state law, during discharge process unless:
      i. Prior notice has been given to the agency, and
      ii. Prior authorization from the agency has been obtained specifically for the individual patient, which may be a verbal acceptance.
5. Physician examination and determination of stability for discharge is required along with a discharge plan and order.

a. EMTALA regulations apply in the ED setting.
b. Person must be alert and oriented to person, place and time.
c. Must be referred to a source of follow-up care if medically necessary.
d. Behavioral health follow-up care, if necessary,
e. Discharge instructions shall be provided to the patient.

6. Food must be offered to the homeless patient.
   a. NIHD Dietary services will have shelf stable food prepared in advance to provide to individuals as need arises.
   b. Documentation of the provision or refusal of food will be required within the medical record.
   c. Meal may be provided prior to discharge or at the time of discharge to go with the patient.
7. Clothing will be offered to the homeless patient if the patient fails to have weather appropriate clothing.
   a. Clothing will be stored in clean condition for dispensing; it is not required to be new clothing.
   b. Completion of Discharge Planning – Weather Appropriate Clothing form is required.
      i. This form serves as documentation of refusal to accept weather appropriate clothing or acceptance of such.
      ii. Form shall be routed to the Nursing Administrative Assistant, who will restock clothing and send form to Health Information Management to scan into the patient chart.
8. Discharge medications shall be arranged via local pharmacies during business hours.
   a. During non-business hours, dose starter packs may be dispensed by the ED Physician as necessary.
   b. Dose starter pack will meet the required labeling and be of limited quantity to be equal to or less than a 72-hour supply.
9. Infectious disease screening will be addressed by the physician based upon presenting symptoms as necessary.
   a. Inyo County Health Officer has not identified any current infectious diseases common within the county currently.
   b. Vaccinations will be provided at the direction of the physician order based upon medical need determination on a case-by-case basis.
10. Transportation will be provided to the homeless patient up to 30 minutes or 30 miles from the District facilities to the post-discharge destination.
11. The homeless patient must be screened for, and helped to enroll in, any affordable health insurance coverage for which he/she is eligible.
    a. The patient will be provided written notice of the hospital's charity care and discount policy, information about eligibility and contact information for the Credit and Billing Information office.
    b. Appointment may be made with Credit and Billing Information office for patient assistance.

Title: Discharge Planning for Homeless Patients	
Scope: Emergency Department & Inpatient Services	Manual: Admissions Services, Case Management, Dietary, Emergency Dept, ICU/CCU, Medical/Surgical, Nursing Administration, Perinatal, Social Services
Source: Chief Nursing Officer	Effective Date: 1/17/19

12. If the patient is accepted by an outside agency for services to meet post-hospital needs for medical or behavioral health needs, the minimum necessary information must be shared with that agency in order to assure continuation of care.

REFERENCES:

1. California Legislative Senate Bill No. 1152, author Senator Hernandez. Effective 1/1/2019.
2. California Hospital Discharge Planning for Homeless Patients, November 2018, California Hospital Association.

CROSS REFERENCE P&P:

1. Discharge Planning for the Hospitalized Patient
2. Language Access Services Policy
3. Language Access Services Program
4. EMTALA Policy
5. Discharge Instructions Emergency Department

Approval	**Date**
CCOC	12/17/18
Utilization Review Committee	12/26/18
Medical Executive Committee	12/28/18
Board of Directors	1/16/19
Last Board of Directors Review	3/18/2020

Developed: 12/2018ta
Reviewed:
Revised:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: ED: Initiation of Buprenorphine in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Department
Source: MNGR ED DISASTER PLANNING	Effective Date: 9/19/19

PURPOSE:

To begin initiation of Medication Assisted Treatment (MAT) for opioid addiction using Buprenorphine in the Emergency Department (ED).

KEY POINTS:

Opioid addiction is a disease. Medication-assisted treatment improves survival and can be implemented successfully in the ED setting using buprenorphine.

Buprenorphine induces analgesia through partial agonist activity at the mu-opioid receptor. It is a high affinity, slow receptor dissociating opioid that partially activates the receptor causing a "ceiling effect", which reduces the risk of respiratory depression with overdose.
Buprenorphine is used in MAT for opioid dependency and has lower abuse potential compared to other medications used for MAT. Patients must be in withdrawal before buprenorphine is administered.
Physicians can administer buprenorphine in the ED, for up to 72 hours, but cannot prescribe for outpatient use without a DEA-X license waiver. Patients must meet certain criteria and be screened for opioid withdrawal prior to receiving a dose of buprenorphine. Patients will then be referred to Care Coordination for ongoing MAT.

DEFINITIONS:

Buprenorphine Facts

- A partial agonist at the mu-opioid receptor.
- Compared to full agonists (i.e. morphine, methadone, oxycodone), buprenorphine only partially activates the receptor causing a “ceiling effect”, minimizing risk of respiratory depression with overdose.
- Has a very high affinity for the mu-receptor so patients must be in withdrawal before buprenorphine is administered.
- Physicians can administer buprenorphine in the ED, but cannot prescribe without a DEA-X license waiver.

POLICY AND PROCEDURE:

1. ED Provider will screen patient for an opioid use disorder and offer treatment
2. ED RN will assess patient for opioid withdrawal
3. If the patient is interested in initiating MAT, Buprenorphine will be initiated by the ED provider (Reference: Buprenorphine Hospital Quickstart Guidelines)
4. The ED Provider will consider adjunctive treatment to ease withdrawal symptoms such as ibuprofen, ondansetron, clonidine, and loperamide

Title: ED: Initiation of Buprenorphine in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Department
Source: MNGR ED DISASTER PLANNING	Effective Date: 9/19/19

5. At discharge, the ED Provider will refer the patient to care coordination for ongoing MAT
6. Upon Discharge ED Provider will offer prescription for Naloxone

REFERENCES:

1. San Francisco General Hospital MAT Protocols
2. Community Hospital of Monterey Peninsula MAT Protocols
3. J Gen Intern Med 2017 Jun - Emergency Department-Initiated Buprenorphine for Opioid Dependence with Continuation in Primary Care: Outcomes During and After Intervention.
4. D'Onofrio G, O'Connor PG, Pantalon MV, et al. Emergency department initiated buprenorphine/naloxone treatment for opioid dependence. JAMA 2015; 313:1636-1644.
5. Addiction. 2017 Nov; 112(11):2002-2010. doi: 10.1111/add.13900. Epub 2017 Aug 16. Cost-effectiveness of emergency department-initiated treatment for opioid dependence.

CROSS REFERENCE P&P:

1.
2.

Committee Approval	Date
CCOC	6/24/19
Emergency Services Committee	7/10/19
Pharmacy & Therapeutics Committee	8/15/19
Medical Executive Committee	9/3/19
Board of Directors	9/18/19
Board of Directors Last Review	9/18/19

Developed: 5/8/2019ap
Reviewed:
Revised:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Department Level of Care Worksheet	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Department Director	Effective Date: 11/01/2013

PURPOSE: To define the methodology to assign the Facility Level of Care based on an acuity system determined by points assigned to the nursing interventions, complexity of the service, resource utilization and the time spent on the episode. The Level of Care Worksheet is to be completed by the RN on duty for every ED patient who presents to our ED. (See Attachment A)

The intent is to capture nursing procedures/processes that are not separately chargeable as procedures. Patients are charged based upon the amount of nursing time and resources necessary to care for them. All assigned points must be supported by the nursing documentation.

POLICY:

1. INITIAL ASSESSMENT
   Current Procedural Terminology defines the following as recognized body systems:
   - Eyes
   - Ears, nose, mouth and throat
   - Cardiovascular
   - Respiratory
   - Gastrointestinal
   - Genitourinary
   - Musculoskeletal
   - Skin
   - Neurologic
   - Psychiatric
   - Hematologic/Lymphatic/Immunologic

   a. Triage: Each ED patient is initially triaged by an RN. Documentation of the chief complaint, arrival status, initial vital signs and a focused nursing assessment is to be included. Additional information may also be included. A point value of 10 will be assigned for this assessment.
   b. ED Visit for Recheck only: Assigned for a return patient who is following-up for a recheck of an established diagnosis from a previous encounter. There can be no new symptoms or problems at this recheck. A point value of 5 will be assigned for this assessment.
   c. Brief Focused Assessment of One (1) System: Assigned for the assessment and documentation of one (1) body system. A point value of 5 will be assigned for this assessment.
   d. Limited Assessment 2 – 3 Systems or Reassessment (with new findings): Assigned for the assessment and documentation of 2 – 3 body. A point value of 10 will be assigned for this assessment.
   e. Multi-System Assessment or Reassessment 4 or more body systems (with new findings): Assigned for the assessment and documentation of 4 or more body systems. A point value of 15 will be assigned for this assessment.
   f. Leaving against Medical Advise (AMA): Assigned for the patient who, against the advice of their medical provider (which included elopement), checks themselves out of

the ED. This is with or without the patient's signature. A point value of 25 will be assigned for this situation.

2. MODE OF ARRIVAL / DISCHARGE
   a. Arrival via Ambulance: Assigned for the patient who is transported to the Emergency Department by an Emergency Medical Services provider and care is assumed by the ED staff. A point value of 10 is assigned.
   b. Admission to Hospital: Assigned for the patient who is admitted through the Emergency Department to the hospital. A point value of 15 is assigned.
   c. Transfer to Acute Care, SNF or Psychiatric Facility: Assigned for the patient who is transported to another Acute Care, Skilled Nursing Facility or Psychiatric Facility where a higher level of care can be performed. A point value of 20 is assigned.

3. DISCHARGE INSTRUCTIONS
   a. Simple: Assigned when there is 0 - 1 item documented in each of the following categories on the discharge instructions given to the patient; Illness, medication, follow-up and/or medical supply. A point value of 5 is assigned for this discharge.
   b. Complex: Assigned when there are 2 or more items documented in any of the following categories on the discharge instructions; Illness, medication(s), follow-up instructions and/or medical supplies. (An example would be 2 medical illnesses, 1 medication and a follow-up instruction). A point value of 10 is assigned for this discharge.
   c. Discharge Instructions Requiring Return Demonstration: Assigned for the patient who is being discharge that has learned and demonstrated a new skill set required to continue their care at home. (An example of this would be crutch fitting & training with return demonstration). A point value of 15 is assigned for this discharge.
   d. Involved Teaching Needs: Assigned when documented that a nurse has utilized additional time and/or resources educating a patient about a new diagnosis, intervention or procedure that the patient or patient's family needs to learn to care for the patient. An example would be a new diagnosis of diabetes, or the use of anticoagulants. A point value of 20 is assigned to this service.

4. MONITORING
   a. Vital Signs 1 – 2 Readings: Assigned for each vital sign check that is documented in the patient's medical record. A patient should receive a vital sign check at admission and upon discharge; therefore each patient should receive this credit. A point value of 5 is assigned.
   b. Orthostatic Vital Signs: Assigned each time a patient receives an orthostatic vital sign assessment and is documented in the medical record. An MD order is required for points to be assigned. A point value of 10 is assigned.
   c. Pulse Oximetry (3 or more readings, or is continuous): Assigned when 3 or more readings are documented or there is continuous monitoring of a patient's O2 saturation. A point value of 10 is assigned.
   d. Multiple Blood Pressure Checks (3 or more): Assigned when 3 or more readings are documented either by the nurse or continuous monitoring via a trend sheet. A point value of 15 is assigned.
   e. Multiple Temperature Checks (3 or more): Assigned when 3 or more readings are documented either by the nurse or continuous monitoring via a trend sheet. A point value of 10 is assigned.

f. Multiple Glasgow Coma Scale checks (3 or more): Assigned when 3 or more readings are documented. A point value of 15 is assigned.
g. Cardiac Monitoring: Assigned for documentation of and a physician order for cardiac monitoring. A point value of 25 is assigned.

5. ROUTINE SUTURE/STAPLE REMOVAL AND WOUND CHECK
When completing this section, no other section will be used, and no other point values from other sections will be added. This is only for removal or checks for procedures completed at our facility.
   a. Triage: Each ED patient is initially triaged by an RN. Documentation of the chief complaint, arrival status, initial vital signs and a focused nursing assessment is to be included. Additional information may also be included. A point value of 0 will be assigned for this assessment.
   b. Wound Cleaning: Assigned when documented that a wound is cleaned, not requiring additional time and/or resources other than the basic supplies and is not associated with a procedure, suturing or other wound closures, performed by the MD. A point value of 0 is assigned for this service.
   c. Suture/Staple Removal: Assigned when documented that a patient comes in for the removal of sutures/staples that were placed at our facility. A point value of 0 is assigned to this service.
   d. Simple Discharge Instructions: Assigned when there is 0 - 1 item documented in each of the following categories on the discharge instructions given to the patient; Illness, medication, follow-up and/or medical supply. For routine wound closure removal or wound check, this should reinforcement of initial visit discharge instructions. A point value of 0 is assigned for this discharge.

6. WOUND CARE, SPRAINS AND FRACTURES
   a. Suture/Staple Removal: Assigned when documented that a patient comes in for the removal of sutures/staples that were placed at another facility. A point value of 10 is assigned to this service.
   b. Wound Cleaning: Assigned when documented that a wound is cleaned, not requiring additional time and/or resources other than the basic supplies and is not associated with a procedure, suturing or other wound closures, performed by the MD. A point value of 10 is assigned for this service.
   c. Laceration Repair with Steri-Strips: Assigned when documented that a laceration is repaired using steri-strips only. A point value of 10 is assigned for this service.
   d. Dressing Small: Assigned when documented that a wound is dressed and the size of the dressing is designated as small. (An example would be a Band-Aid or a 2 X 2 dressing.) The application of dressings is credited when not associated with a procedure performed by the MD. A point value of 5 is assigned.
   e. Dressing Medium: Assigned when documented that a wound is dressed and the size of the dressing is designated as medium. (An example would be a 4 X 4 dressing.) The application of dressings is credited when not associated with a procedure performed by the MD. A point value of 10 is assigned.
   f. Dressing Large: Assigned when documented that a wound(s) is dressed and the size of the dressing is designated as large. (An example would be a head wound requiring a head wrap and/or there are multiple dressings applied. The application of dressings is credited when not associated with a procedure performed by the MD. A point value of 15 is assigned.

g. Placement of Aces, Slings and all Pre-Made Splints: Assigned when documented that the nurse applies an ace, sling or any pre-made splint to a patient. A point value of 15 is assigned.
h. C-Spine Stabilization: Assigned when documented that the nurse initially applies, or confirms proper placement of a cervical collar when received from EMS. A point value of 30 is assigned.

7. MEDICATIONS AND IV'S
   a. Medications – Oral, Suppository, Topical and Drops (not IV or Injections SQ or IM): Assigned when documented that an oral, suppository, topical and/or dropped medication is administered to the patient. This does not include IV, IVP, SQ or IM administration of medication. A point value of 5 for each medication administered is assigned.
   b. IV Start or Saline Lock Start: Assigned when documented that an IV or saline lock is started but there is no medication or fluid given through this site. Credit is given when a blood draw is done through the site. A point value of 10 is assigned for each new site started. A point value of 10 is assigned.
   c. Each Additional IV Attempt: Assigned when documented for each attempt that is made to start an IV or saline lock prior to the successful intervention. A point value of 5 for each additional attempt is assigned.

8. TREATMENTS
   a. Simple Eye Irrigation: Assigned when documented that the nurse irrigates the eye when not associated with a procedure performed by the MD. A point value of 5 is assigned to this service.
   b. Eye Irrigation with Morgan Lenses: Assigned when documented that the nurse irrigates the eye in conjunction with the use of the Morgan Lenses. A point value of 15 is assigned to this service.
   c. Eye Exam (Stain/slit lamp), w/o FB removal: Assigned when documented that there is an examination of the eye using medication and/or a slit lamp. Credit is given when it is not associated with a foreign body removal. A point value of 15 is assigned to this service.
   d. Suction / Irrigation: Assigned when documented that the nurse performs suction or irrigation, by any route. This is assigned each time either of these interventions is performed. A point value of 20 is assigned to either/each of these services.
   e. Enema administration (other than Fleets enema): Assigned when documented that the nurse administers an enema, that is not a Fleets enema. A point value of 20 is assigned to this service.
   f. Preparation for Surgery: Assigned when documented that the nurse performed duties specific to preparing the patient for surgery. A point value of 20 points is assigned to this service.
   g. Cerumen Removal: Assigned when documented that the nurse removed cerumen from the ear. This is assigned for each time or location (right or left ear) the process is performed. A point value of 20 is assigned to this service.

9. OB / GYN
   a. Fetal Heart Tones: Assigned when documented that a nurse monitors the fetal heart tones on an OB patient. A point value of 10 is assigned to this service.
   b. Pelvic Exam: Assigned when documented that the nurse attends during a pelvic exam of an OB patient. A point value of 20 is assigned to this service.

Title: Emergency Department Level of Care Worksheet	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Department Director	Effective Date: 11/01/2013

10. TESTS
    a. X-Ray Simple: Assigned when documented that the nurse coordinates X-rays for the patient. This is assigned each time a patient is taken to X-Ray or a portable unit is brought to the patients' bedside. It is not assigned for each X-Ray taken at a single sitting. A point value of 5 is assigned to this service.
    b. X-ray Complex or requiring Nurse Accompany: Assigned when documented that the nurse coordinates a complex X-Ray procedure (example would be an MRI or tests requiring preps), or the nurse is required to accompany the patient to have the X-Ray performed. This is assigned each time the nurse coordinates a separate test/sitting or accompanies the patient for the test, not for each test performed at one sitting. A point value of 15 is assigned to this service.
    c. Lab Draw and/or Specimen Pick-Up: Assigned when documented each time that a lab was drawn by the nurse and sent to the lab, or the lab comes to the ER department to perform the draw. It is also assigned each time any specimen that has been collected, is documented that it was sent to the lab. A point value of 5 is assigned for time this service is performed.
    d. Specimen Collection – Urine, Sputum, Wound, Slides and/or Swabs: Assigned each time it is documented that a specimen (of any sort) is collected by the nurse. A point value 10 is assigned to each service performed.
    e. Breathing Treatment by RT or ABG's: Assigned each time it is documented that the nurse coordinated one of these RT services. A point value of 5 is assigned to each of these services.
    f. Visual Acuity: Assigned when documented that a visual acuity test is performed by the nurse. A point value of 5 is assigned to this service.
    g. Hemoccult / Gastroccult / Chemstix / Accu-check: Assigned when documented each time one of these tests is performed by the nurse. Points are assigned for each test done or multiple tests of the same type at different times. A point value of 5 is assigned to this service.
    h. Bladder Scan: Assigned when documented that the nurse performs a bladder scan. Points are awarded each time a scan is performed. A point value of 10 is assigned to this service.
    i. 12 Lead ECG: Assigned each time there is a physician order for and documentation that the nurse has performed or coordinated the ECG ordered test. A point value of 15 is assigned to this service.

11. SPECIAL NEEDS / EDUCATION
    a. Emotional Needs Pediatric (Age 14 and Under): Assigned when documented that there was additional time and/or resources required by the nursing staff to take care of the needs of the patient or patient's family. This does not include involved teaching requirements (which are addressed separately). It also does not include the use of interpreters. A point value of 10 is assigned to this service.
    b. Emotional Needs Adult: Assigned when documented that there was additional time and/or resources required by the nursing staff to take care of the needs of the patient or patient's family. This does not include involved teaching requirements (which are addressed separately). It also does not include the use of interpreters. A point value of 10 is assigned to this service.
    c. Social Service or Mental Health Intervention (Non-5150): Assigned when documented that a nurse has coordinated an intervention by Social Services or the Mental Health

Department. Mental Health intervention would not be for an Involuntary Psychiatric Hold (5150). A point value of 10 is assigned to this service.

d. Combative, Confused, Coordination with Mental Health (5150), Security, Police Involvement or Comatose: Assigned when documented that a nurse has specifically dealt with one of the conditions listed above or has coordinated intervention for any of the above mentioned services or conditions. This would include Mental Health intervention for an Involuntary Psychiatric Hold (5150). A point value of 15 is assigned to this service.

e. Hospice, Home Health, Oxygen / Airway Referral: Assigned when documented that a nurse has coordinated the services of or a referral for hospice care, home health, and oxygen or airway agency. A point value of 15 is assigned to this service.

12. ASSISTS OR OBSERVATION TIME NOT COVERED IN PROCEDURES

Assists and Observation time are combined to account for the cumulative time a nurse spends at a patients' bedside administering to a patient, and that time is not separately covered under other methods of care. The time may be continuous or frequent in nature, and must be documented as time assisting or observing the patient. (Examples of this time would be assisting the patient to the bathroom, stand by assists for ambulation or feeding the patient). It would not include services that by their very nature are standard nursing duties or when assisting an MD in a procedure.

a. Assists (1 – 15 minutes): Assigned when documented that a nurse has assisted/observed the patient for a period of time of 1 – 15 minutes in duration. A point value of 10 is assigned for this service.

b. Assists (16 – 30 minutes): Assigned when documented that a nurse has assisted/observed the patient for a period of time of 16 – 30 minutes in duration. A point value of 15 is assigned for this service.

c. Assists (31 – 60 minutes): Assigned when documented that a nurse has assisted/observed the patient for a period of time or 31 – 60 minutes in duration. A point value of 20 is assigned for this service.

d. Each Additional Hour: Assigned when documented that a nurse has assisted/observed the patient for each additional hour beyond the first hour. A point value of 20 is assigned for this service.

13. TOTALS

a. Initial Assessment: Total of the points in this category
b. Mode of Arrival / Discharge: Total of the points in this category
c. Discharge Instructions: Total of the points in this category
d. Monitoring: Total of the points in this category
e. Wound Care, Sprains and Fractures: Total of the points in this category
f. Medications and IV's: Total of the points in this category
g. Treatments: Total of the points in this category
h. OB / GYN: Total of the points in this category
i. Tests: Total of the points in this category
j. Special Needs / Education: Total of the points in this category
k. Assists Not Covered in Procedures: Total of the points in this category

Title: Emergency Department Level of Care Worksheet	
Scope: Emergency Department	Manual: Emergency Department
Source: Emergency Department Director	Effective Date: 11/01/2013

14. CRITICAL CARE SERVICES: Per the current CPT Manual, Critical Care is defined as'… the direct delivery by the medical and nursing staff in the care for a critically ill or critically injured patient. A critical illness or injury acutely impairs one or more vital organ systems resulting in a high probability of imminent or life threatening deterioration in the patient's condition. This requires high complexity decision making to assess, manipulate and support vital system function(s) to treat single or multiple vital organ system failure and/or to prevent further life threatening deterioration of the patient's condition. Although critical care typically requires interpretation of multiple physiologic parameters and/or application of advanced technology(s), critical care may be provided in life threatening situations when these elements are not present.' For the determination on charging for the facility fees, and based upon this description, it is at the nurse's discretion whether the care of a patient falls under this description or not. If critical care is charged, then there is no other Level of Care determination or charge. There may be other charges for procedures performed in the care of this critical patient.

15. Level of Care
    a. Level 1 — 0 – 25 Points
    b. Level II — 26 – 55 Points
    c. Level III — 56 – 85 Points
    d. Level IV — 86 – 125 Points
    e. Level V — > 125 Points
    f. Critical Care — Critical Care up to 74 Minutes
    g. Critical Care — Critical Care: Each additional 30 Minutes
16. Done by: The initials of the nurse initially completing the Level of Care Worksheet should be placed on this line.
17. Checked by: The initials of the person reviewing or auditing the initial review should be placed on this line.

Approval	Date
CCOC	5/21/18
Business, Coding and Compliance Committee	5/8/18
Board of Directors	6/20/18
Last Board of Director review	6/19/19

Developed: 10/13
Revised:
Retired: Charge Policy, Emergency Department
Reviewed: 04/17gr, 4/18gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Department Telephone Advice Information	
Scope: Emergency Department	Department: Emergency Department
Source: Emergency Department Manager	Effective Date: 6/2001

PURPOSE:
To define the parameters of advice or information that may be given to a person calling the Emergency Department staff seeking advice or medical information.

POLICY:
It is the policy of Northern Inyo Hospital that any person that calls the Emergency Department (ED) for telephone advice or information shall be informed that we do not give advice to persons that were not recent ED patients. It is our policy to only give information to patients calling for clarification of their discharge instructions or to relay or discuss their test results. It is our policy to give advice to emergency type of calls (911) that are put through to us by law enforcement or other EMS dispatch.

PROCEDURE:
1. Any person that calls and asks to be connected to the ED (and not the clerk) should be asked if they are calling for advice. If they are calling for advice they should be asked if they are calling about a recent ER visit. If they are calling about a recent visit they should be transferred to the ED.

2. Recent ED patients calling for advice, clarification of instructions or test results will receive advice and /or results specific to their diagnosis and current symptoms or concerns. The Registered Nurse (RN) or Qualified Medical provider (QMP) will review the chart and the appropriate advice will be given. If at any time it is unclear as to what the concern or question is, or if the patient feels their condition is worsening they will be advised to call their doctor, return to the ED or call 911.

3. 911 Call patched through to the Emergency Department:
In a life-threatening situation, while waiting for medical help to arrive, law enforcement may put a call through to the ED via phone from a person that needs immediate medical assistance and information. In this case the most appropriate QMP or ED RN may give advice over the phone.

4. Emergency Services (EMS) radio or telephone patched through to the ED:
If further advice or orders are needed after initial EMS protocols are initiated on scene, the QMP may give further orders to EMS providers.

5. When a caller that is asking for advice is not asking about a recent ED visit, they should be transferred to extension 3111. They will then be given the following message.

> **You have been connected to the ER telephone advice line.**
> **Our policy does not allow us to give telephone advice to people that we have not seen.**
> **Hang up and dial 911 if you have a medical emergency.**
> **If you need to see a doctor, you may come to the ER. You can be seen and treated even if you cannot pay.**
> **If you have a medical question your doctor may be able to help you**
> **If you need poison control advice, that number is 1-800-222-1222.**
> **If you have a question about a recent ER visit, discharge instructions or test results please call back and tell the operator you need to talk to an ER doctor or nurse about your ER visit.**

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Department Telephone Advice Information	
Scope: Emergency Department	Department: Emergency Department
Source: Emergency Department Manager	Effective Date: 6/2001

Documentation:
1. A brief note about the call and any further action will be documented as an addendum in the patient's original visit chart.
2. Any advice given over the phone or base station radio to EMS must be documented in the ambulance run sheet.

REFERENCE:

CROSS REFERENCE:
1. Pre- Hospital Policy
2. MICN Policy

Approval	**Date**
CCOC	5/21/18
Emergency Services Committee	7/11/18
Medical Executive Committee	8/7/18
Board of Directors	8/15/18
Last Board of Directors Review	6/19/19

Index Listings: Telephone Advice/Information
Revised: 6/2001; 10/2001; 2/2004; 6/11as; 2/15as; 5/18gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Medical Screening of Patients on Hospital Property	
Scope: Hospital Wide	Manual: Emergency Dept
Source: ED Nurse Manager	Effective Date: 12/15/2004

PURPOSE:
To ensure a uniform process for providing a medical screening examination and necessary stabilizing treatment for any individuals situated on campus or within 250 yards of the main hospital building, and who request, or on whose behalf a request is made for emergency medical evaluation and treatment.

DEFINITION:
"250 Yard Perimeter" – an area encompassed within a 250-yard radius of the main hospital building. Sites covered within this area include sidewalks, streets, alleys, parking lots, parks, public areas (hallways, lobbies, etc.) of hospital-owned medical buildings, and non-owned buildings that are rented, leased or operated by the hospital. Sites within the 250 yard radius that are exempt from response include, but are not limited to, private physician's offices, private residences, private businesses and buildings that accommodate any business or services that are not hospital owned or operated.

POLICY:

1. Upon request for an evaluation of what is believed by an individual, or a person requesting such an evaluation on behalf of an individual, to be a possible emergency medical condition, the individual (patient) will receive a medical screening examination (MSE) and any necessary stabilizing treatment that can be provided within the capability of the department, including resources available within the main hospital.
2. If a request is made for evaluation of an individual who is located at a site covered by the 250-yard guidelines noted above, the Emergency Department shall dispatch a licensed staff member, if staff is available, or a call to 911 will be placed to attend the patient and to immediately report preliminary findings back to the Emergency Department physician.
3. The staff member will take a walkie-talkie or cellular phone to facilitate communication with the ED.
4. At the direction of the emergency department physician, a determination will be made as to the appropriate disposition of the patient.
5. If transport of the patient is required back to the emergency department, to conduct the medical screening examination and provide stabilizing treatment, appropriate transport options shall be considered including, but not limited to, calling 911 for assistance.
6. The ED shall notify police promptly if traffic control is needed or there is evidence of a violent or criminal act.
7. Should a patient refuse to consent to examination or stabilizing treatment, a staff member shall further offer the patient a medical examination and stabilizing treatment.
8. The staff member shall contact the emergency department physician who, in turn, shall make a reasonable effort to inform the patient, or patient's representative, of the benefits to the patient of further evaluation or treatment and the reasonably foreseeable risks, if known; to the patient should such evaluation or treatment not be accepted.
9. The staff member shall take all reasonable steps to secure the written informed refusal (Against Medical Advice – AMA) of the individual. If the patient or his/her legal representative fails or refuses to sign the form, the attempts at counseling and efforts to seek the patient's/legal representative's signature shall be documented.
10. Should the patient request transport or transfer to another hospital or care provider, the staff member shall notify the emergency department physician for further direction.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Medical Screening of Patients on Hospital Property	
Scope: Hospital Wide	Manual: Emergency Dept
Source: ED Nurse Manager	Effective Date: 12/15/2004

Approval	**Date**
CCOC	11/6/17
Emergency Department Committee	1/10/18
Medical Executive Committee	2/6/18
Board of Directors	2/21/18
Last Board of Director review	6/19/19

Initiated: 3/04
Reviewed: 7/11as, 02/17 kp
Revised: 10/2017gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Emergency Medication and Code Blue Crash Cart Policy	
Scope: Hospital Wide	**Department:**
Source: Pharmacy Director	**Effective Date:** 9/21/18

PURPOSE:

The purpose of this policy is to ensure that all emergency medications and code blue crash cart equipment and supplies in the hospital are consistently available, controlled, and secure. Included in the term "Crash Cart" is the adult crash cart and the Broselow crash cart.

POLICY:

1. The Director of Pharmacy shall ensure the availability of a sufficient inventory of medical staff approved emergency drugs in the pharmacy and patient care areas.

2. All code blue crash carts will be arranged similarly and contain identical medications and supplies, to ensure the most efficient use of these by all hospital staff. The only differences in crash carts will be between the adult crash cart and the Broselow crash cart.

3. Emergency drugs shall be readily available to the patient-care staff but not accessible to patients, visitors, and unauthorized personnel.

4. Adult crash carts will be functional for anyone exceeding the Broselow tape length or weight of greater than 36 Kg and the Broselow crash cart will be functional for pediatric patients from 3 Kg through 36 Kg. The Adult crash carts will have the ACLS algorithms attached and the Broselow cart will have the Broselow tape and PALS algorithms attached for emergency therapy.

5. Neo-natal emergency medications will be kept in the Obstetrical Department.

6. Perinatal emergency medications will be kept in the Obstetrical Department.

7. All non-medication containing drawers on the Broselow cart will be secured with a yellow securement device, and the last three numbers of each drawer's securement device will be individually checked and documented daily.
    a. If a yellow securement device is missing or broken, it will be reported to the house supervisor, the contents will be rechecked and a new yellow securement device placed on the drawer.

8. Emergency drugs supplies shall not be used as a routine source, but shall be reserved for emergency use when immediate availability is necessary.

9. The Pharmacy and Therapeutics Committee, with advice from the ED and ICU Committees, will determine the drugs and quantity of each to be kept in the Code Blue Crash Carts (Emergency Drug Supply).

10. The Pharmacy and Therapeutics Committee, with advice from the ED and ICU Committees, will review the drugs and quantity of each to be kept in the Code Blue Crash Carts (Emergency Drug Supply) at least yearly.

11. Emergency medications in the crash carts shall be located in drawers (currently the supply is divided into 4 separate drawers). Each drawer shall contain a clearly marked portable container (called a tray), which is sealed by a pharmacist in such a manner that a seal must be broken to gain access to the drugs within.

12. The adult and Broselow crash cart drawers containing medications shall be further sealed with a red breakaway lock. Such locks shall be stored in the pharmacy and shall be available only to a pharmacist.

13. The contents of the container shall be listed on the outside cover and shall include the earliest expiration date of any drugs within.

14. If the medications are used during regular working hours, the pharmacist will replace the tray(s) used and will reseal the crash cart with one or more breakaway red locks.

15. If the medications are used after pharmacy hours, the shift supervisor will replace the used tray with a pre-filled and sealed replacement tray.

16. The shift supervisor will replace the used drawers with locked drawers from the locked supervisor cabinet.

17. The next morning, a pharmacist will inspect the drawer contents, update the outdate list on the crash cart, and re-seal the medication drawers with a red pharmacy lock.

18. The department/unit staff will check the crash cart at least once daily whenever the department is open. They will check and record the lock number(s) of the medication drawers and of the supply section on the checklist.
    a. Broken or missing medication drawer locks will be reported to the pharmacist on duty, or the shift supervisor immediately.
    b. If the supply section lock is broken or the number does not match the checklist, the supplies will be checked and relocked. The new lock number will be recorded on the checklist.

19. In addition to crash cart locations for emergency drug supplies, the following departments store special emergency drug supplies:

    a. PACU – Lipid Rescue Kit
    b. Emergency Department – Lipid Rescue Kit, Sexual Assault Kit. Hyperthermia Cart
    c. Outpatient Infusion – Adverse Drug Reaction Kit
    d. Obstetrical Unit - Eclampsia Box, Neonatal Boxes, and Post-partum Hemorrhage Kit in each birthing room, Neonatal Box in the nursery, Lipid Rescue Kit
    e. Medical/Surgical floor – Lipid Rescue Kit
    f. Surgery Unit - 2 Anesthesia Carts, one Lipid Rescue Kit
    g. Radiology - an Adverse Drug Reaction box.
    h. CT – Adverse Drug Reaction Box
    i. MRI – an Adverse Drug Reaction box
    j. EKG – Regadenoson Rescue Kit

k. RHC – Emergency Supply Cart

20. A pharmacist shall seal these special emergency drug supplies with a red lock, and the contents with expiration dates shall be listed on the outside of the box.

21. A pharmacist shall inspect the emergency drug supply at least every 30 days. Records of such inspections shall be kept for at least three years.

Contents of the Emergency Crash Cart are listed in the attachments to this policy.

REFERENCES:

1. Pennsylvania Patient Safety Authority: Clinical Emergency: Are You Ready in Any Setting? *Pennsylvania Patient Safety Advisory*, June 2010;7(2)52-60.
2. M Davies, et al: A Simple Solution for Improving Reliability of Cardiac Arrest Equipment Provision in Hospital. Resuscitation, 2014(85)1523-1526.
3. S Sones: Is Your Code Cart Ready? *Outpatient Surgery*, October 2008

CROSS REFERENCES:

1. Access to Medications in the Absence of a Pharmacist
2. Emergency Medication Trays Policy

Committee Approval	**Date**
CCOC	9/23/19
Pharmacy and Therapeutics Committee	12/19/19
Medical Executive Committee	01/07/20
Board of Directors	1/15/20
Last Board of Directors Review	3/18/2020

Revised: 10/05, 3/11, 4/14, 1/20
Supersedes: 02/01

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Emergency Medication Trays Policy	
Scope: Hospital Wide	Manual: Nursing All Unit, Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 11/21/19

PURPOSE:

The purpose of this policy is to ensure that all emergency medications and crash cart equipment and supplies in the hospital are consistently available, controlled, and secure.

POLICY:

1. The Director of Pharmacy shall ensure the availability of a sufficient inventory of medical staff approved emergency drugs in the pharmacy and patient care areas.

2. All crash carts with the exception of Broselow carts will be arranged similarly and contain identical medications and supplies, to ensure the most efficient use of these by all hospital staff. Broselow carts have a specific inventory of medications and implements which vary from regular crash carts. Each crash cart has a specific inventory list attached/or on the cart.

3. Emergency drugs shall be readily available to the patient-care staff but not accessible to patients, visitors, and unauthorized personnel.

4. Crash carts will be functional for all ages – pediatric through geriatric. All crash carts will have ACLS and PALS algorithms for emergency therapy. Of note the District has added Broselow carts specifically for pediatric use.

5. Additional neo-natal emergency equipment will be kept in the Obstetrical Department.

6. Emergency drugs supplies shall not be used as a routine or stat source, but shall be reserved for emergency use when immediate availability is necessary.

7. The Pharmacy and Therapeutics Committee, with advice from the ED and ICU Committees (Resuscitation ED Subcommittee) , will determine the drugs and quantity of each to be kept in the Crash Carts (Emergency Drug Supply) and will review the supply yearly.

8. Emergency medications in the regular crash carts shall be located in drawers (currently the supply is divided into 4 separate drawers). Each drawer shall contain a clearly marked portable container (called a tray), which is sealed by a pharmacist in such a manner that a seal must be broken to gain access to the drugs within. Broselow carts will have compartmented slots to house medications (trayless).

9. The contents of the container shall be listed on the outside cover and shall include the earliest expiration date of any of the drugs within.

10. If the medications are used during regular working hours, the pharmacist will replace the tray(s) used and will reseal the crash cart with a breakaway red lock.

11. If the medications are used after pharmacy hours, the shift supervisor will take the used tray to a secure storage area and will replace it with a pre-filled and sealed replacement tray located in the secure area. Pharmacy will be notified of the use as soon as they reopen.

12. The supervisor will reseal the crash cart with a yellow lock.
13. The next morning, a pharmacist will replenish trays or drawers that were opened while the pharmacy was closed. These trays will be restocked, checked, have the lists updated and will be signed by the pharmacist that reseals the tray. These trays will be taken to the crash cart that was opened after pharmacy hours and the pharmacist checks that the crash cart is complete and updates the outdate list on the crash cart, and re-seals crash cart with a red lock.

14. All Crash Carts will be checked as per the Crash Cart and defibrillator Check Policy.

15. In addition to crash cart locations for emergency drug supplies, other departments store special emergency drug supplies. These are approved yearly by the Pharmacy and Therapeutics committee.
16. A pharmacist shall seal these special emergency drug supplies with a breakaway lock, and the contents with expiration dates shall be listed on the outside of the box.

17. A pharmacist shall inspect the emergency drug supply at least every 30 days. Records of such inspections shall be kept for at least three years.

REFERENCES:

1. AM Pearson, et al: Crash Cart Drug Drawer Layout and Design. Proceedings of the Human Factors and Ergonomics Society 56th Annual Meeting 2012. Human Factors and Ergonomics Society Inc.
2. Are You Ready for an Emergency? Don't Get Caught Unprepared. *Same-Day Surgery*, September 2010;34(9)97-101

CROSS REFERENCES:

1. **NIHD** Access to Medications in the Absence of a Pharmacist

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Emergency Medication Trays Policy	
Scope: Hospital Wide	Manual: Nursing All Unit, Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 11/21/19

Committee Approval	**Date**
Clinical Consistency Oversight Committee	10/21/19
Pharmacy and Therapeutics Committee	10/17/19
Medical Executive Committee	11/5/19
Board of Directors	11/20/19
Board of Directors Last Review	3/18/2020

Revised	10/10 4/19FGL, 11/19fl
Reviewed	10/05, 9/06, 9/07, 9/08, 9/09, 9/10

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Emergency Room Overcrowding**	
Scope: Dept. Specific	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date: 7/15/18

PURPOSE:

As ambulance diversion in the 911 System is not an option under general circumstances since the closest hospital is 45 miles away, this policy will address the issue of Emergency Department (ED) overcrowding, indicators and possible solutions.

POLICY:

Each patient will be triaged on arrival for care and the approximate wait time will be projected.

Indicators of reduced capacity include:

1) Large volume of ED patients awaiting medical screening.
2) High acuity patients currently receiving treatment.
3) Increase patient to nurse ratio.
4) Decreased bed availability in-house.
5) Decreased bed availability at receiving specialty hospitals.
6) Patients leaving without being seen (LWBS) during periods of long wait.
7) Patients waiting transfer to specialty facility.

Procedures and Strategies to relieve overcrowding should include:

1) Notify House Supervisor of overcrowding.
2) Request additional physician or qualified medical provider coverage for medical screening.
3) Nursing staff called in "on-call" to improve ratios and efficiency.
4) Patients in waiting room should be updated as to the time frame when they may be seen and reassessed every hour and as needed.
5) Using chairs and hallways for lower level acuity patients.
6) Establish a "results" waiting and pending discharge area.
7) During full surge capacity with no relief, notify all nurse managers and on-call administrator and establish Hospital Incident Command.
   a) Mobilize Emergency Management Plan.
   b) Utilize surge tent when needed.
8) House supervisor to obtain information on potential receiving hospitals.
9) In disaster situations, working with public health for additional triage and medical screening sites.

References:

1. Emergency Nurses Association, www.ena.org

Cross Reference Policies:

1. Emergency Management Plan

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Emergency Room Overcrowding**	
Scope: Dept. Specific	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date: 7/15/18

Committee Approval	**Date**
Clinical Consistency Oversight Committee	11/6/17
Emergency Services Committee	5/16/18
Medical Executive Committee	6/5/18
Board of Directors	6/20/18
Last Board of Directors Review	6/19/19

Reviewed: 10/2017 gr
Revised: 04/2018 gr

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: EMTALA Policy	
Scope: ED & Perinatal	Manual: CPM – Admission, Discharge, Transfer (ADT)
Source: ED & Disaster Nurse Manager	Effective Date:

PURPOSE:
To establish guidelines for providing appropriate medical screening examinations ("MSE") and any necessary stabilizing treatment or an appropriate transfer for the individual as required by EMTALA, 42 U.S.C. § 1395dd, and all Federal regulations and interpretive guidelines promulgated there under.

POLICY:
An EMTALA obligation is triggered when an individual comes to a dedicated emergency department ("DED") and:

1. The individual or a representative acting on the individual's behalf requests an examination or treatment for a medical condition; or
2. A prudent layperson observer would conclude from the individual's appearance or behavior that the individual needs an examination or treatment of a medical condition.

Such obligation is further extended to those individuals presenting elsewhere on hospital property requesting examination or treatment for an emergency medical condition ("EMC"). Further, if a prudent layperson observer would believe that the individual is experiencing an EMC, then an appropriate MSE, within the capabilities of the hospital's DED (including ancillary services routinely available and the availability of on-call physicians), shall be performed. The MSE must be completed by an individual (i) qualified to perform such an examination to determine whether an EMC exists, or (ii) with respect to a pregnant woman having contractions, whether the woman is in labor and whether the treatment requested is explicitly for an EMC. If an EMC is determined to exist, the individual will be provided necessary stabilizing treatment, within the capacity and capability of the facility, or an appropriate transfer as defined by and required by EMTALA. Stabilization treatment shall be applied in a non-discriminatory manner (*e.g.*, no different level of care because of an individual's race, color, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender identification), genetic information, preexisting medical condition, physical or mental disability, insurance status, economic status, ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient).

PROCEDURE:
1. **When an MSE is Required**

   A hospital must provide an appropriate MSE within the capability of the hospital's emergency department, including ancillary services routinely available to the DED, to determine whether or not an EMC exists: (i) to any individual, including a pregnant woman having contractions, who requests such an examination; (ii) an individual who has such a request made on his or her behalf; or (iii) an individual whom a prudent layperson observer

would conclude from the individual's appearance or behavior needs an MSE. An MSE shall be provided to determine whether or not the individual is experiencing an EMC or a pregnant woman is in labor. An MSE is required when:

a. The individual ***comes to a DED*** of a hospital and a request is made by the individual or on the individual's behalf for examination or treatment for a medical condition, including where:
   i. The individual requests medication to resolve or provide stabilizing treatment for a medical condition.
   ii. The individual arrives as a transfer from another hospital or health care facility. Upon arrival of a transfer, a physician or qualified medical person ("QMP") must perform an appropriate MSE. The physician or QMP shall provide any additional screening and treatment required to stabilize the EMC. The MSE of the individual must be documented. This type of screening cannot be performed by the triage nurse. If an EMC is determined to exist and the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under EMTALA ceases.

   Note: The MSE and other emergency services need not be provided in a location specifically identified as a DED. The hospital may use areas to deliver emergency services that are also used for other inpatient or outpatient services. MSEs or stabilization may require ancillary services available only in areas or facilities of the hospital outside of the DED.

b. The individual arrives on the ***hospital property other than a DED*** and makes a request or another makes a request on the individual's behalf for examination or treatment for an EMC.
   i. Screening where the individual presented: If an individual is initially screened in a department or location on-campus other than the DED, the individual may be moved to another hospital department or facility on-campus to receive further screening or stabilizing treatment without such movement being a transfer. The hospital shall not move the individual to an off-campus facility or department (such as an urgent care center or satellite clinic) for an MSE.
   ii. Transporting to the DED: The hospital may determine that movement of an individual to the hospital's DED may be necessary for screening. However, common sense and individual judgment should prevail. When determining how best to transport the individual to the DED (means of transport, accompanying qualified personnel, equipment, etc.), the following factors should be taken into account but shall not be determinative:

- *Whether the hospital DED has the personnel and resources necessary to render adequate medical treatment to all existing patients in the DED,*
- *Whether responding to the emergency could send hospital personnel into harm's way or unreasonably endanger or jeopardize the lives or health of such personnel, and*
- *Whether non-hospital paramedics, emergency medical technicians, or other qualified personnel are more appropriate to respond.*

iii. Transporting to other hospital property: The facility may direct individuals to other hospital-based facilities that are on hospital property and operated under the hospital's provider number. However, the hospital should not move an individual to a hospital-based facility located off-campus, such as a rural health clinic or physician office, for an MSE or other emergency services. Individuals should only be moved to the hospital-based on-campus facility when the following conditions are met:

- all persons with the same medical condition are moved to this location regardless of their ability to pay for treatment,
- there is a bona fide medical reason to move the individual, and
- QMP accompany the individual.

Note: Unless outpatient testing is associated with an individual presenting to the DED with a request for an emergency medical screening, it should not be performed in the emergency department. Individuals presenting for outpatient testing should be registered as outpatients and not as emergency patients.

Note: Anyone may make the request for an MSE or treatment described in both a. and b. above. Specifically,

- A minor (child) can request an examination or treatment for an EMC. Hospital personnel should not delay the MSE by waiting for parental consent. If, after screening the minor, it is determined that no EMC is present, the staff may wait for parental consent before proceeding with further examination and treatment. **Note:** For additional information regarding treatment of minors, please consult your operations counsel.
- Emergency Medical Services (EMS) personnel may request an evaluation or treatment on an individual's behalf.

Example: If an individual is on a gurney or stretcher or in an ambulance or on a helipad at the hospital and EMS personnel, the individual, or a legally responsible person acting on the individual's behalf, requests examination or treatment of an EMC from hospital staff, an MSE must be provided.

c. The individual arrives ***on the hospital property***, either in the DED or property other than the DED, ***and no request is made*** for evaluation or treatment, but the appearance or behavior of the individual would cause a prudent layperson observer to believe that the individual needed such examination or treatment.

d. An individual is in a ***ground or air ambulance*** for purposes of examination and treatment for a medical condition at a hospital's DED, and the ambulance is either:
   i. *owned and operated by the hospital,* even if the ambulance is not on hospital grounds, or
   ii. neither owned nor operated by the hospital, but *on hospital property*.

e. A ***community-wide plan*** exists for specific hospitals to treat certain EMCs (*e.g.*, psychiatric, trauma, physical or sexual abuse). Prior to transferring the individual to the community plan hospital, an MSE must be performed and any necessary stabilizing treatment rendered.

f. If a ***law enforcement official*** requests hospital emergency personnel to provide ***medical clearance*** for incarceration, the Hospital has an EMTALA obligation to provide an MSE to determine if an EMC exists. If an EMC is found to exist and is stabilized, the Hospital has met its EMTALA obligations and additional requests for assessment or testing are not required. All facilities must remain in compliance with federal and state HIPAA regulations.

g. If a ***law enforcement official*** brings a person who is exhibiting behavior that suggests that he or she is intoxicated to the DED for ***drawing of the blood alcohol*** and asks for an MSE, or if a prudent layperson observer would believe that the individual needed examination or treatment for a possible EMC, then an MSE must be performed. This is required because some medical conditions could present behaviors similar to those of an inebriated individual.

h. If an individual presents to a facility which does not have the capability to perform a rape kit when one is needed, the hospital's obligation is to provide an appropriate MSE without disturbing the evidence and transfer the individual to a hospital that has the capability to gather the evidence. Transfer must occur only in compliance with hospital policies and procedures that are Medicare Hospital Conditions of Participation (CoP) and licensure compliant.

i. ***Born Alive Infant.*** When an infant is born alive in the DED, if a request is made on the infant's behalf for screening for a medical condition or if a prudent layperson would conclude based on the infant's appearance or behavior that the infant needed examination or treatment for a medical condition, the hospital and physician must provide an MSE. If the infant is born alive elsewhere on the hospital's campus and a prudent layperson observer would conclude based on the born alive infant's appearance or behavior that the infant was suffering from an EMC, the hospital and medical staff must perform an MSE to determine whether or not an EMC exists. If an EMC exists, the hospital must provide for stabilizing treatment or an appropriate transfer.

iii. The individual requests medication to resolve or provide stabilizing treatment for a medical condition.
iv. The individual arrives as a transfer from another hospital or health care facility. Upon arrival of a transfer, a physician or qualified medical person ("QMP") must perform an appropriate MSE. The physician or QMP shall provide any additional screening and treatment required to stabilize the EMC. The MSE of the individual must be documented. This type of screening cannot be performed by the triage nurse. If an EMC is determined to exist and the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under EMTALA ceases.

Note: The MSE and other emergency services need not be provided in a location specifically identified as a DED. The hospital may use areas to deliver emergency services that are also used for other inpatient or outpatient services. MSEs or stabilization may require ancillary services available only in areas or facilities of the hospital outside of the DED.

2. **Extent of the MSE**

a. **Determine if an EMC exists.** The hospital must perform an MSE to determine if an EMC exists. It is not appropriate to merely "log in" or triage an individual with a medical condition and not provide an MSE. Triage is not equivalent to an MSE. Triage entails the clinical assessment of the individual's presenting signs and symptoms at the time of arrival at the hospital in order to prioritize when the individual will be screened by a physician or other QMP.

b. **Definition of MSE.** An MSE is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether the individual has an EMC or not. It is not an isolated event. The MSE must be appropriate to the individual's presenting signs and symptoms and the capability and capacity of the hospital.

c. **An on-going process.** The individual shall be continuously monitored according to the individual's needs until it is determined whether or not the individual has an EMC, and if he or she does, until he or she is stabilized or appropriately admitted or transferred. The medical record shall reflect the amount and extent of monitoring that was provided prior to the completion of the MSE and until discharge or transfer.

d. **Judgment of physician or QMP.** The extent of the necessary examination to determine whether an EMC exists is generally within the judgment and discretion of the physician or other QMP performing the examination function according to algorithms or protocols established and approved by the medical staff and governing board.

e. **Extent of MSE varies by presenting symptoms.** The MSE may vary depending on the individual's signs and symptoms:
   i. Depending on the individual's presenting symptoms, an appropriate MSE can involve a wide spectrum of actions, ranging from a simple process involving only a brief history and physical examination to a complex process that also involves performing ancillary studies and procedures such as (but not limited to) lumbar punctures, clinical laboratory tests, CT scans and other diagnostic tests and procedures.
   ii. *Pregnant Women:* The medical records should show evidence that the screening examination includes, at a minimum, evaluation of fetal heart tones, regularity and duration of uterine contractions, fetal position and station, cervical dilation, and status of membranes (*i.e.,* ruptured, leaking and intact), to document whether or not the woman is in labor. A woman experiencing contractions is in true labor unless a physician, certified nurse-midwife or other QMP acting within his or her scope of practice as defined by the hospital's medical staff bylaws and State medical practice acts, certifies that after a reasonable time of observation, the woman is not in labor. The recommended timeframe for such physician certification of the QMP's determination of false labor should be within 24 hours of the MSE, however, the medical staff bylaws, rules and regulations can provide guidance on the timeframe.
   iii. *Individuals with psychiatric or behavioral symptoms:* The medical records should indicate both medical and psychiatric or behavioral components of the MSE. The MSE for psychiatric purposes is to determine if the psychiatric symptoms have a physiologic etiology. The psychiatric MSE includes an assessment of suicidal or homicidal thoughts or gestures that indicates danger to self or others, and, as applicable, an assessment of the patient's inability to provide or utilize food, shelter, or clothing due to a mental disorder.

Non-discrimination. The hospital must provide an MSE and necessary stabilizing treatment to any individual regardless of an individual's race, color, ethnicity, religion, ancestry, national origin, citizenship, age, sex, marital status, sexual orientation (including gender identification), genetic information, preexisting medical condition, physical or mental disability, insurance status, economic status, ability to pay for medical services or any other category protected by law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.

3. **Who May Perform the MSE**

a. Only the following individuals may perform an MSE:
   i. A qualified physician with appropriate privileges;
   ii. Other qualified licensed independent practitioner (LIP) with appropriate competencies and privileges; or
   iii. A qualified staff member who:

- is qualified to conduct such an examination through appropriate privileging and demonstrated competencies;
- is functioning within the scope of his or her license and in compliance with state law and applicable practice acts (*e.g.*, Medical or Nurse Practice Acts);
- is performing the screening examination based on medical staff approved guidelines, protocols or algorithms; and
- is approved by the facility's governing board as set forth in a document such as the hospital bylaws or medical staff rules and regulations, which document has been approved by the facility's governing body and medical staff. It is not acceptable for the facility to allow informal personnel appointments that could change frequently.

b. **Qualified Medical Personnel.** QMPs may perform an MSE if licensed and certified, operating under the supervision of a physician, approved by the hospital's governing board through the hospital's by-laws, and only if the scope of the EMC is within the individual's scope of practice.

i. The designation of QMP is set forth in a document approved by the governing body of the hospital. Each individual QMP approved to provide an MSE under EMTALA must be appropriately credentialed and must meet the requirements for annual evaluations set forth in the protocol agreements with physicians and the State's medical practice act, nurse practice act or other similar practice acts established to govern health care practitioners. Only appropriately credentialed APRNs, PAs and physicians may perform MSEs in the DED.

ii. **Psychiatric QMP.** The ED physician shall consult the QMP providing the behavioral assessment for psychiatric purposes but shall remain the primary decision-maker with regard to transfer and discharge of the individual presenting to the DED with psychiatric or behavioral emergencies. Should an individual with a psychiatric or behavioral emergency present to a behavioral department of a hospital that meets the requirements of a DED, that department is responsible for ensuring that the individual has the appropriate MSE, including any behavioral examination, and providing necessary stabilizing treatment.

iii. **Labor and Delivery QMP.** QMPs in the labor and delivery DED may be appropriately-approved RNs and must communicate their findings as to whether or not a woman is in labor to the obstetrician, CNM, or other MD on call, or the ED physician.

iv. **Limitations.** The hospital has established a process to ensure that:
a) a physician examines all individuals whose conditions or symptoms require physician examination;

b) an ED physician on duty is responsible for the general care of all individuals presenting themselves to the emergency department; and
c) the responsibility remains with the ED physician until the individual's private physician or an on-call specialist assumes that responsibility, or the individual is discharged.

4. **No Delay in Medical Screening or Examination**

a. **Reasonable Registration Process.** An MSE, stabilizing treatment, or appropriate transfer will not be delayed to inquire about the individual's method of payment or insurance status, or conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered. The facility must render emergency services and care without first questioning the patient or any other person as to his or her ability to pay therefore. The patient or his/her legally responsible relative or guardian are required to provide insurance or credit information, or sign an agreement to pay, promptly after the services are rendered. The hospital may seek non-payment information from the individual's health plan about the individual, such as medical history. In the case of an individual with an EMC, once the hospital has conducted the MSE and has initiated stabilizing treatment, it may seek authorization for all services from the plan as long as doing so does not delay completion of the stabilizing treatment.

b. **Managed Care.** For individuals who are enrolled in a managed care plan, prior authorization from the plan shall NOT be required or requested before providing an appropriate MSE and initiating any further medical examination and necessary stabilizing treatment.

c. **EMS.** A hospital has an obligation to see the individual once the individual presents to the DED whether by EMS or otherwise. A hospital that delays the MSE or stabilizing treatment of any individual who arrives via transfer from another facility, by not allowing EMS to leave the individual, could be in violation EMTALA and the Hospital CoP for Emergency Services. Even if the hospital cannot immediately complete an appropriate MSE, the hospital must assess the individual's condition upon arrival of the EMS service to ensure that the individual is appropriately prioritized based on his or her presenting signs and symptoms to be seen for completion of the MSE.

d. **Contacting the individual's physician.** An ED physician or non-physician practitioner may contact the individual's personal physician at any time to seek advice regarding the individual's medical history and needs that may be relevant to medical treatment and screening of the individual, so long as this consultation does not inappropriately delay services.

e. **Financial Responsibility Forms.** The performance of the MSE and the provision of stabilizing treatment will NOT be conditioned on an individual's completion of a financial responsibility form, an advance beneficiary notification form, or payment of a co-payment for any services rendered.

f. **Financial Inquiries.** Individuals who inquire about financial responsibility for emergency care should receive a response by a staff member who has been well trained to provide information regarding potential financial liability. The staff member who provides information on potential financial liability should clearly inform the individual that the hospital will provide an MSE and any necessary stabilizing treatment, regardless of his or her ability to pay. Individuals who believe that they have an EMC should be encouraged to remain for the MSE.

Note: There is no delay in the provision of an MSE or stabilizing treatment if: (i) there is not an open bed in the DED; (ii) there are not sufficient caregivers present to render the MSE and/or stabilizing treatment; and (iii) the individual's condition does not warrant immediate screening and treatment by a physician or QMP.

5. **Refusal to Consent to Treatment**

a. **Written Refusal – Partial Refusal of Care or Against Medical Advice.** If a physician or QMP has begun the MSE or any stabilizing treatment and an individual refuses to consent to a test, examination or treatment or refuses any further care and is determined to leave against medical advice, after being informed of the risks and benefits and the hospital's obligations under EMTALA, reasonable attempts shall be made to obtain a written refusal to consent to examination or treatment using the form provided for that purpose or document the individuals refusal to sign the Against Medical Advice Form (see Against Medical Advice Form). The medical record must contain a description of the screening and the examination, treatment, or both if applicable, that was refused by or on behalf of the individual.

b. **Waiver of Right to Medical Screening Examination.** If an individual refuses to consent to examination or treatment and indicates his or her intention to leave prior to triage or prior to receiving an MSE or if the individual withdrew the initial request for an MSE, facility personnel must document the patient's reason for leaving. Documentation should reflect that the hospital offered to provide screening and treatment before patient's refusal.

c. **Documentation of Information.** The physician or nurse must document that the individual has been informed of the risks and benefits of the examination and/or treatment but refused to sign the form.

d. **Documentation of Unannounced Leave.** If an individual leaves the facility without notifying facility personnel, this must be documented upon discovery. The documentation must reflect that the individual had been at the facility and the time the individual was discovered to have left the premises. Triage notes and additional records must be retained. If the individual leaves prior to transfer or leaves prior to an MSE, the information should be documented on the individual's medical record. If an individual has not completed a Sign-In Sheet, an ED staff member should complete a sheet and if the individual's name is not known a description of the individual leaving should be entered on the form. All individuals presenting for evaluation or treatment must be entered into the Central Log.

6. **Stabilizing Treatment Within Hospital Capability**

The determination of whether an individual is stable is not based on the clinical outcome of the individual's medical condition. An individual has been provided sufficient stabilizing treatment when the physician treating the individual in the DED has determined, within reasonable clinical confidence, that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or with respect to an EMC of a woman in labor, that the woman has delivered the child and placenta; or in the case of an individual with a psychiatric or behavioral condition, that the individual is protected and prevented from injuring himself/ herself or others. For those individuals who are administered chemical or physical restraints for purposes of transfer from one facility to another, stabilization may occur for a period of time and remove the immediate EMC, but the underlying medical condition may persist and, if not treated for longevity, the individual may experience exacerbation of the EMC. Therefore, the treating physician should use great care when determining if the EMC is in fact stable after administering chemical or physical restraints.

a. **Stable.** The physician or QMP providing the medical screening and treating the emergency has determined within reasonable clinical confidence, that the EMC that caused the individual to seek care in the DED has been resolved although the underlying medical condition may persist. Once the individual is stable, EMTALA no longer applies. (The individual may still be transferred; however, the "appropriate transfer" requirement under EMTALA does not apply.)

b. **Stabilizing Treatment Within Hospital Capability and Transfer.** Once the hospital has provided an appropriate MSE and stabilizing treatment within its capability, an appropriate transfer may be effected by following the appropriate transfer provisions. (See Transfer Policy.) If there is a disagreement between the physician providing emergency care and an off-site physician (*e.g.*, a physician at the receiving facility or the individual's primary care physician if not physically present at the first facility) about whether the individual has been provided sufficient stabilized treatment to effect a transfer, the medical judgment of the transferring physician takes precedence over that of the off-site physician.

Refer to the hospital's Transfer Policy for additional directions regarding transfers of those individuals who are not medically stable. If a hospital has exhausted all its capabilities and is unable to stabilize an individual, an appropriate transfer should be implemented by the transferring physician.

c. **Stabilizing Treatment and Individuals Whose EMCs Are Resolved.** An individual is considered stable and ready for discharge when, within reasonable clinical confidence, it is determined that the individual has reached the point where his or her continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient or later as an inpatient, provided the individual is given a plan for appropriate follow-up care with the discharge instructions. The EMC that caused the individual to present to the DED must be resolved, but the underlying medical condition may persist. Hospitals are expected within reason to assist/provide discharged individuals the necessary information to secure follow-up care to prevent relapse or worsening of the medical condition upon release from the hospital.

7. When EMTALA Obligations End

The hospital's EMTALA obligation ends when a physician or QMP has made a decision:

a. That no EMC exists (even though the underlying medical condition may persist);
b. That an EMC exists and the individual is appropriately transferred to another facility; or
c. That an EMC exists and the individual is admitted to the hospital for further stabilizing treatment; or
d. That an EMC exists and the individual is stabilized and discharged.

Note: A hospital's EMTALA obligation ends when the individual has been admitted in good faith as an inpatient, whether or not the individual has been stabilized. An individual is considered to be an inpatient when the individual is formally admitted to the hospital by a physician's order. A hospital continues to have a responsibility to meet the patient's emergency needs in accordance with hospital CoPs. A patient in observation status is not considered admitted as an inpatient, therefore, EMTALA obligations continue.

j. ***EMTALA Waivers and Requirements During Pandemics and Other Declared Emergencies.***

a. Alternative Screening Sites on Campus for Screening during a Pandemic (No Waiver Required.) For the screening of influenza like illnesses, the hospital may establish an alternative screening site(s) on campus. Individuals may be redirected to these sites AFTER being logged in. The redirection and logging can take place outside the entrance to the DED. However, the person doing the directing must be qualified (*e.g.*, an RN or QMP) to recognize individuals who are obviously in need of immediate treatment in the DED. The MSEs must be conducted by qualified personnel.

b. Alternative Screening Site Off-Campus (No Waiver Required.) The hospital may encourage the public to go to an off-campus hospital-controlled site for the screening of influenza like illness. However, the hospital may NOT tell an individual who has already come to the DED to go to the off-site location for the MSE. The off-campus site for influenza like illnesses should not be held out to the public as a place that provides care for EMCs in general on an urgent, unscheduled basis.

c. EMTALA Waivers.

i. A hospital operating under an EMTALA waiver will not be sanctioned for an inappropriate transfer or for directing or relocating an individual who comes to the DED to an alternative off-campus site, for the MSE if the following conditions are met:

1. The transfer is necessitated by the circumstances of the declared emergency in the emergency area during the emergency period (as those terms are defined in the hospital's EMTALA Transfer Policy);
2. The direction or relocation of an individual to receive medical screening at an alternate location is pursuant to an appropriate State emergency preparedness plan or, in the case of a public health emergency that involves a pandemic infectious disease, pursuant to a State pandemic preparedness plan;
3. The hospital does not discriminate on the basis of an individual's source of payment or ability to pay;
4. The hospital is located in an emergency area during an emergency period; and
5. There has been a determination that a waiver of sanctions is necessary.

ii. An EMTALA waiver can be issued for a hospital only if:

1. The President has declared an emergency or disaster under the Stafford Act or the National Emergencies Act; and
2. The Secretary of HHS has declared a Public Health Emergency (PHE); and
3. The Secretary invokes his or her waiver authority including notifying Congress at least 48 hours in advance; and
4. The waiver includes waiver of EMTALA requirements and the hospital is covered by the waiver.

c. In the absence of CMS notification of area-wide applications of the waiver, the hospital must contact CMS and request that the waiver provisions be applicable to the hospital.
d. In addition, in order for an EMTALA waiver to apply to the hospital and for sanctions not to apply, (i) the hospital must activate its disaster protocol, and (ii) the State must have activated an emergency preparedness plan or pandemic preparedness plan in the emergency area, and any redirection of individuals for an MSE must be consistent with such plan.
e. Even when a waiver is in effect, there is still the expectation that everyone who comes to the DED will receive an appropriate MSE, if not in the DED, then at the alternate care site to which they are redirected or relocated.

Except in the case of waivers related to pandemic infectious disease, an EMTALA waiver is limited in duration to 72 hours beginning upon activation of the hospital's disaster protocol. In the case of a PHE involving pandemic infectious disease, the general EMTALA waiver authority will continue in effect until the termination of the declaration of the PHE. However, the waiver may be limited to a date prior to the termination of the PHE declaration, as determined by CMS. If a State emergency/pandemic preparedness plan is deactivated in the area where the hospital is located prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date. Likewise, if the hospital deactivates its disaster protocol prior to the termination of the PHE, the hospital no longer meets the conditions for an EMTALA waiver and the hospital waiver would cease to be in effect as of the deactivation date.

REFERENCES:

1. EMTALA: A Guide to Patient Anti Dumping Laws. (2009)

CROSS REFERENCE P&P:

1. Emergency Medical Screening of Patients on Hospital Property.
2. Evaluation and Screening of Patients Presenting to Emergency Department.
3. Medical screening Exam for the Obstetrical patient- Standardized Procedure.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: EMTALA Policy	
Scope: ED & Perinatal	Manual: CPM – Admission, Discharge, Transfer (ADT)
Source: ED & Disaster Nurse Manager	Effective Date:

Approval	**Date**
CCOC	8/28/17
Perinatal/Pediatrics Committee	10/20/17
Emergency Services Committee	9/13/17
Medical Executive Committee	11/7/17
Board of Directors	11/15/17
Last Board of Directors Review	6/19/19

Developed: 8/2017
Reviewed:
Revised:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Entering an ED Admission (observation, surgery, inpatient status) into Health Information System	
Scope: Admission Services, Emergency Department, House Supervisor	Manual: Emergency Dept
Source: ED Manager	Effective Date: 2/22/18

PURPOSE:
The patient who has been admitted from the ED as an observation, surgery or inpatient must have a status change from ED outpatient to the correct status per the physician's orders.

POLICY:
1. House Supervisor shall be notified of every potential patient status change to determine bed and staff availability.
2. After an admitting order has been obtained for inpatient, observation or surgery patients, the ED Clerk provides the information to the Admitting Clerk for entry into the HIS.

PROCEDURE:
1. The Medical Staff Practitioner electronically enters admission orders for ED patients as Observation, Surgery, or Inpatient.
2. The electronically entered Orders print to the ED Clerk.
3. The ED Clerk notifies the House Supervisor (HS) of the patient admitting status including.
    a. Patient's name
    b. Diagnosis
    c. Date of birth
    d. Admitting physician
    e. Telemetry requirements
    f. ED admit
    g. Location: Med, ICU, Ped, Ped Neo, OPO Med, OPO ICU, OP Surg, IP Surg, OB Test, Med OB, OB Vaginal, or C-section
    h. Time admit orders written. If the patient's an observation patient, the time the patient arrives to the observation location needs documented for payment purposes.
4. HS assigns bed and notifies ED Clerk.
5. HS notifies receiving department.
6. The ED Clerk writes the assigned bed number on the printed orders and makes two (2) copies.
    a. One copy is given to the ED Admitting Clerk.
    b. One copy goes to the receiving unit or House Supervisor.
    c. The original copy goes to the ED RN taking care of the patient.
        1) This copy goes with patient to the floor.

REFERENCES:
1. California Code of Regulations, Title 22

CROSS REFERENCE P&P/Plans:
1. Admission, Discharge, Transfer of Patients
2. Conditions of Admission

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Entering an ED Admission (observation, surgery, inpatient status) into Health Information System	
Scope: Admission Services, Emergency Department, House Supervisor	Manual: Emergency Dept
Source: ED Manager	Effective Date: 2/22/18

Approval	**Date**
NEC	11/6/17
Emergency Services Committee	1/10/18
Medical Executive Committee	2/6/18
Board of Directors	2/21/18
Last Board of Director Review	6/19/19

Developed: 7/13
Reviewed: 10/2017gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Evaluation and Medical Screening of Patients Presenting to the Emergency Department**	
Scope: Emergency Department	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date: 5/20/2004

PURPOSE:
To ensure that all patients coming to the hospital requesting emergency services receive an appropriate Medical Screening Examination as required by the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C., Section 1395 and all Federal regulations and interpretive guidelines promulgated there under.

DEFINITIONS:

1) **Medical Screening Examination** is the process required to reach with reasonable clinical confidence, the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. Such screening must be done within the facility's capabilities and available personnel, including on-call physicians. The medical screening examination is an ongoing process and the medical records must reflect continued monitoring based on the patient's needs and continue until the patient is either stabilized or appropriately transferred.

POLICY:

1) All persons seeking treatment will be evaluated by a triage RN to determine chief complaint and to determine acuity according to Emergency Severity Index (ESI) level..
2) OB patients will be treated in accordance with the "EVALUATION OF PREGNANT PATIENTS IN THE EMERGENCY DEPARTMENT" policy.
3) A qualified medical personnel (QMP) will evaluate and perform a medical screening examination, which will include:
    a. History
    b. Physical exam of affected systems
    c. Physical exam of potentially affected systems and known chronic conditions
    d. Any testing necessary to rule out the presence of legally defined emergency medical conditions (lab, x-ray, CT, etc.)
    e. Use of on-call personnel if needed. to complete above
    f. Use of on-call physicians if needed to diagnose and stabilize the patient
    g. Discharge/transfer vital signs
    h. Documentation of all aspects of the Medical Screening Examination
4) The patient's primary physician (PMD) may perform the medical screening exam in the hospital.
5) The ER physician will perform the medical screening exam for any patient needing immediate treatment unless the PMD is immediately available.
6) All persons seeking treatment in the Emergency Room for an emergent condition will have a medical screening examination completed without consideration of their ability to pay for services.

References:

1. EMTALA: A Guide to Patient Anti- Dumping Laws (2009)

Cross Reference P & P

1. EMTALA Policy
2. Triage
3. Medical Screening Examination for Obstetrical Patient

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Evaluation and Medical Screening of Patients Presenting to the Emergency Department**	
Scope: Emergency Department	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date: 5/20/2004

Committee Approval	Date
CCOC	10/23/17
ER Department Committee	3/14/18
Medical Executive Committee	5/7/18
Board of Directors	5/16/18
Last Board of Director review	6/19/19

Revised: 10/2017
Reviewed: 6/11as; 2/15as

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Evaluation of Pregnant Patients in the Emergency Department**	
Scope:	Department: **Emergency Dept, Perinatal**
Source: Emergency Dept Nurse Manager	Effective Date: 1/9/2004

PURPOSE:
To ensure quality care for pregnant patients presenting in the Emergency Department for evaluation and potential treatment

POLICY:

1. All pregnant patients presenting to the Emergency Department will initially be seen in accordance with ER medical screening policies and procedures.

2. Stable patients at 20 weeks or greater gestation will be sent to the Perinatal Department for evaluation. The on-call OB provider will be consulted by the Perinatal RNs, and will see the patient as necessary (in accordance with EMTALA and patient condition). If the patient is cleared (discharged) from the Perinatal Department by the OB provider and has non-OB complaints that were not addressed by the OB provider, the patient shall return to the ED to be evaluated by the ER physician.

3. Patients who are unstable will not be transferred to the Perinatal Department until stabilized.

4. Patients at less than 20 weeks gestation will be evaluated by the ER physician who will consult, as needed, with the OB physician on-call.

5. For patients at 20 weeks or greater gestation who are not immediately transferred to the Perinatal Department, the ER physician will consult with the on-call OB provider.

6. If patient appears to be in active labor or delivery appears imminent, notify Perinatal Department to prepare for the patient and accompany patient to Perinatal Department.

7. If delivery in progress, patient will be cared for by the ER MD until the on-call OB provider arrives. Perinatal RNs may be requested to assist in the ED if available.

8. The decision to admit or discharge a patient at 20 weeks or greater gestation will be at the discretion of the OB provider evaluating the patient for pregnancy-related problems. If not pregnancy-related, then ER procedures will be followed.

9. For patients at 20 weeks or greater gestation who are not immediately transferred to the Perinatal Department, a Perinatal RN may evaluate the patient in the ED if staffing allows and both departments are agreeable. If in doubt, the OB evaluation should take place on the Perinatal Department.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Evaluation of Pregnant Patients in the Emergency Department**	
Scope:	Department: **Emergency Dept, Perinatal**
Source: Emergency Dept Nurse Manager	Effective Date: 1/9/2004

REFERENCES:

1. EMTALA; California Hospital EMTALA Manual; A guide to patient anti-dumping laws. Lipton, M.S. 2018.

CROSS REFERENCES:

1. Emergency Department Triage Protocols
2. EMTALA Policy

Committee Approval	Date
CCOC	4/23/18
Emergency Services Committee	5/16/18
Perinatal-Pediatrics Committee	4/20/18
Medical Executive Committee	6/5/18
Board of Directors	6/20/18
Last Board of Directors Review	2/18/2020

Revised: 2/2018af
Index Listing: OB Patients, Evaluation of Pregnant Patients in Emergency Department

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Handling of Infants/Fetus/Stillborns and Genetic Workup	
Scope:	Manual: Emergency Dept, Perinatal, Rural Health Clinic, Surgery
Source: Surgery Nurse Manager	Effective Date: 7-23-2008

PURPOSE:

Guidelines for nursing personnel to appropriately care for neonatal deaths or fetal demise (stillborn) when sending infant to pathology as a specimen or the mortuary.

POLICY:

Every neonatal death and/or fetal demise (stillborn) shall be processed in a legal manner. The attending Physician will determine the gestational age of the infant/fetus.

The following guidelines/protocol will be followed when sending an infant to pathology. Included is a protocol when a genetic workup has been requested or when the body is to be sent to the mortuary.

SPECIAL CONSIDERATIONS:

Physician order required __X_ YES ___NO
Procedure may be performed by __X_RN __X_LVN ___OR TECH
Special education required ___YES __X_NO
Review policy and procedure.

PROCEDURE:

FETUS OF 20 WEEKS OR LESS GESTATION OR LESS THAN 400 GRAMS

(May be handled as a specimen)

1. A permit for disposal is required
2. Clinician's statement on age of gestation is a prime factor, if reasonable. Upper limit is 27cm. crown to heel length and fetal weight less than 400 grams.
3. If clinical estimate of age is not given, you must contact the primary physician.
4. Place in **STERILE NORMAL SALINE** and send to pathology lab.

FETUS OF MORE THAN 20 WEEKS GESTATION , 27CM CROWN TO HEEL OR WEIGHT MORE THAN 400 GRAMS MUST BE SENT TO THE MORTUARY.

1. Contact the clinician immediately with information that a death certificate is required.
2. If an autopsy is requested, it will be completed by a Pathologist, preferably a Forensic Pathologist.
3. All paperwork must be filled out and given to the mortuary at the time they arrive to receive the body.

PROTOCOL FOR HANDLING GENETIC WORKUP

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Handling of Infants/Fetus/Stillborns and Genetic Workup	
Scope:	Manual: Emergency Dept, Perinatal, Rural Health Clinic, Surgery
Source: Surgery Nurse Manager	Effective Date: 7-23-2008

1. If a genetic workup is requested ***(regardless of gestational age.)*** **The Placenta is the most important tissue for genetic testing.**

   A. ***First priority*** is obtaining the **Placenta** for genetic testing
   Placenta is to send to pathology in a sterile container. **DO NOT PUT FORMALIN ON PLACENTA. If during normal working hours send immediately to Pathology without placing the tissue in any solution.** If after normal working hours for pathology, place the placenta in sterile normal saline and refrigerate until morning, then send to pathology.
   Physician can harvest a one inch square of placenta and place it in a Sterile container of sterile saline and place in the refrigerator if they Choose. This is a sufficient sample for the pathologist.

   B. ***Second priority is obtaining a cord blood in a green top tube*** (green top tubes contain sodium heparin). If possible obtain at least 3cc of cord blood before cord is severed. ***This is not to be refrigerated.*** Label the tube with name, date, and time collected. N***ote that specimen is from cord blood. Send to pathology.***

   C. If ***cord blood is not obtainable*** then both the fetus and placenta must be sent to pathology. ***If the fetus is 20 weeks or less*** it is to be preserved in ***sterile normal saline,and refrigerated.*** The ***placenta*** must also be placed in normal saline and be refrigerated. If the ***fetus is more than 20 weeks*** it is to be wrapped and placed in the refrigerator on "A" floor (after hours).

   D. All the proper paperwork and information is to accompany the specimen and be sent to the pathology lab or to be placed in the box outside the path. lab (after hours - see below).

****NOTE*** - Paperwork is essential not only for the mortuary but also for genetic workup. All information including date of birth, live birth or fetal demise, sex and name of baby, parent's name, insurance and the type of test requested is vital. Please fill out the form completely.

PATHOLOGY LABORATORY HOURS

6:30am - 3:00pm, Monday - Friday
During working hours send specimens to the path lab.

AFTER-HOURS

Place fetus and placenta in the lab refrigerator on "A" floor and place a note in the pathology box outside of path lab, or send an e-mail to notify the techs that there is a specimen to pick-up.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Handling of Infants/Fetus/Stillborns and Genetic Workup	
Scope:	Manual: Emergency Dept, Perinatal, Rural Health Clinic, Surgery
Source: Surgery Nurse Manager	Effective Date: 7-23-2008

DOCUMENTATION:

The correct and complete information is essential and must accompany the fetus either to the mortuary or to path for genetic workups. The disposition of the fetus will be documented on the operating room record or nursing notes for OB.

REFERENCE: NIH Pathology procedure/ Perinatal Unit Policy & Procedure.

Committee approval needed __X_Yes __ No
Surgery Tissue Committee: 7-23-08
Responsibility for review and maintenance: Surgery Nurse Manager
Index listings: Stillborn handling of/ Genetic studies for stillborn / Infants/ Death in OR (Infants) Infants and stillborn handling protocol.

Revised 9/97 BS
Revised 03/05/2008 BS
Last Board of Director review: 1/17/18; 1/16/19; 6/19/19: 2/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **In-House Transport of Ventilator Dependent Patients**	
Scope: NIH	Department: **Respiratory Care, Emergency Department, ICU, Radiology**
Source: Director of Cardiopulmonary	Effective Date: 10-15-2012

PURPOSE:

To maintain ventilatory support on all ventilated patients that are being transferred from ICU/ED to X-ray or any other department for diagnostic or therapeutic procedures and from ED to ICU.

POLICY:

Transportation of mechanically ventilated patients should only be undertaken following a careful evaluation of the risk-benefit ratio.
When transporting any patient that is on a ventilator, a Respiratory Care Practitioner, and a Registered Nurse must accompany the patient.
Patient transport includes preparation, movement to and from and time spent at destination.
Patients that are on ventilatory support and need to go to MRI will be hand ventilated in the MRI suite. The attending physician needs to approve of this.

CONTRAINDICATIONS:

1. Inability to provide adequate oxygenation and ventilation during transport either by manual ventilation, portable ventilator or standard ventilator.
2. Inability to maintain acceptable hemodynamic performance during transport.
3. Inability to maintain airway control during transport.
4. Transport will not be undertaken unless all the necessary members of the transport team are present.

HAZARDS & COMPLICATIONS:

1. Hyperventilation during manual ventilation.
2. Loss of PEEP.
3. Inadvertent disconnection of intravenous access.
4. Movement may cause disconnection from the ventilatory support and respiratory compromise.
5. Movement may result in accidental extubation.
6. Loss of oxygen supply may lead to hypoxemia.
7. Ventilator-associated pneumonia has been associated with transport.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **In-House Transport of Ventilator Dependent Patients**	
Scope: NIH	Department: **Respiratory Care, Emergency Department, ICU, Radiology**
Source: Director of Cardiopulmonary	Effective Date: 10-15-2012

PROCEDURE:

1. Nursing staff will notify the Respiratory Therapist of the time and location of the transport.

2. The Respiratory Therapist will obtain the necessary equipment for the transport including but not limited to:

   a. VersaMed I Vent
   b. Resuscitation-bag with mask.
   c. Peep adaptor if necessary
   d. Full O2 E cylinder on I Vent
   e. Spo2 monitor
   f. ETCO2 monitor or colorimetric CO2 detector
   g. Stethoscope

There are two methods of transporting patients, the preferred way:

1. If the patient is in the ICU on the PB 840 it is acceptable to use the VersaMed I-vent. Use the same settings as the PB 840, or as close as possible on the I-Vent. It is preferable to place the patient on the I-Vent for 5-10 minutes before transporting to monitor the patient on a different ventilator. If the patient is not tolerating the I-Vent and the patient still needs to be transported follow procedure # 2.

a. The I-Vent can be used as a transport ventilator; it has an internal battery that will last approximately 2 hours on a full charge and an E Oxygen Cylinder that will last approximately 2 hours at 100%.

b. When transporting the patient be aware of the possible pull on the endotracheal tube from the ventilator. If necessary have someone push the ventilator while you are holding the ET tube.

c. When reaching you destination it is preferable to connect to piped in oxygen if available and plug the ventilator in.

Title: **In-House Transport of Ventilator Dependent Patients**	
Scope: NIH	Department: **Respiratory Care, Emergency Department, ICU, Radiology**
Source: Director of Cardiopulmonary	Effective Date: 10-15-2012

Option # 2 If the patient is not tolerating the I-Vent and the patient still needs to be transported.

a. If two therapists are working one will manually ventilate the patient while the other therapist moves the PB 840 ventilator to desired location.

b. If one therapist is working, the nurse or the therapist can bag the patient while someone else moves the PB 840 ventilator to the desired location.

c. Once at the desired location the patient will be connected to the ventilator on the same settings.

DOCUMENTATION

1. The patient should be monitored with Spo2 and ETCo2 during the procedure.

   Document the transfer, ventilator check and breathe sounds after moving the patient to X-Ray and then after the return trip back to ICU or ED.

REFERENCES:

1. AARC Clinical Practice Guideline
   "In-Hospital Transport of the Mechanically Ventilated Patient".
   http://www.rcjournal.com/cpgs/pdf/06.02.721.pdf

2. AARC Clinical Practice Guideline
   "Capnography/Capnometry During Mechanical Ventilation: 2011
   http://rc.rcjournal.com/content/respcare/56/4/503.full.pdf

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **In-House Transport of Ventilator Dependent Patients**	
Scope: NIH	Department: **Respiratory Care, Emergency Department, ICU, Radiology**
Source: Director of Cardiopulmonary	Effective Date: 10-15-2012

Committee Approval	**Date**
Clinical Consistency Oversight Committee	11/20/17
Medical Services/ICU Committee	1/25/18
Medical Executive Committee	2/6/18
Board of Directors	2/21/18
Last Board Review	6/19/19

Developed: 8/2012
Reviewed:
Revised: 10/6/2017
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Interfacility Transfer Guidelines**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Perinatal**
Source: Emergency Dept Nurse Manager	Effective Date:

PURPOSE:
To establish guidelines for the Interfacility transfer of patient by RN's employed by the hospital and to defend the protocols per the directing EMS agencies to be followed by EMT-1A, EMT-II and EMT-P's.

POLICY:
An ACLS certified RN preferred to accompany a patient during an Interfacility transfer via ambulance.

RN INTERFACILITY TRANSFER:

Prior to leaving the hospital:

1. Receive a complete report on the patient.
2. Check completeness of Interfacility transfer form.
3. Obtain copies of patient chart, labs, x-ray or any other information requested by receiving facility.
4. Obtain physician orders for care of patient during transfer. If possible, include orders for acute emergencies, such as following ACLS guidelines in respiratory or cardiac arrest or deteriorating patient status, that may be used in the event of inability to contact physician and patient has acute changes.
5. Bring all necessary medications, IV solutions, etc. including orders to follow in event of radio communication failure or patient deterioration, i.e., following ACLS guidelines in event of respiratory or cardiac arrest. Determine the necessity of cardiac monitoring. Bring necessary personal belongings of patient.
6. Familiarize yourself with ambulance equipment, O^2, suction, etc.

During Transfer:

1. The RN shall remain in the patient compartment of the ambulance at all times.
2. Obtain VS as ordered by physician and PRN per patient condition. Document on Interfacility transfer form.
3. In the event of a cardiac arrest or other types of life threatening situations request ambulance attendant to respond to the nearest hospital Code 3. Follow orders per physician intervention.

Upon Arrival At Receiving Facility:

1. Accompany the patient to their designated room and give a full report to the nurse (at times patients are seen in the ER first, give report to ER nurse).
2. Give copies of patient chart and the original transfer form (completed) to the receiving RN. Save a copy of the Interfacility transfer form to bring back to Northern Inyo for placement in NIH patient chart.

Upon return to Northern Inyo write on edit sheet the time you left NIH and the time of arrival back to Northern Inyo. Under remarks write "ambulance transfer".

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Interfacility Transfer Guidelines**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Perinatal**
Source: Emergency Dept Nurse Manager	Effective Date:

** Remember that when an NIH nurse accompanies a patient during transfer, a miscellaneous charge slip needs to be completed. The nursing supervisor has a supply of these that are already stamped "Code #00601". For an hourly charge (local only) the code is #0060, and the time of the transfer needs to be documented on the charge slip.

EMT-II/EMT-P INTERFACILITY TRANSFER

Transfer of Patient with Peripheral Lines:

POLICY:
During transport, a certified EMT-P, EMT-II or supervised EMT-P, or EMT-II trainee who has received appropriate training may monitor peripheral lines delivering intravenous fluids, provided the following conditions are met:

1. A verbal order by the transferring physician is provided to the transporting ALS ambulance.
2. No medications will be added to the intravenous fluids by EMT-II's and EMT-P's during transport unless under the direction of the Base Hospital or under radio communication failure.
3. EMT-II's and EMT-P's may transport intravenous solutions with added medication(s) which appear on the ICEMA drug list (as medications for intravenous use) that are approved for their scope of practice.
4. EMT-P's may monitor and administer medications through pre-existing vascular access.
5. EMT-P's may monitor heparin or saline locks.
6. EMT-P's may monitor IV solutions containing Potassium <40 mEq/L.
7. EMT-P's may monitor thoracostomy tubes.
8. The following are the only fluids that will be allowed for transport:
   Any combination/concentration of:
   1. D5/water with:
      a. Normal saline
      b. Lactated Ringers
      c. Isolyte or Isolyte M
   2. Normal Saline
   3. Lactated Ringers

For list of approved drugs and concerns over what is in the Scope of Practice, refer to EMT-II (LALS) EMT-P (ALS) protocol. Section 13000 refer to policies for transport of patients with peripheral lines, (as stated above), thoracostomy tubes, and DNR policy. For specific procedure that may be performed, refer to that procedure protocol in the appropriate (LALS), (ALS), pre-hospital manual found in ER.

EMT-1A INTERFACILITY TRANSPORT:
In the pre-hospital setting or during Interfacility transport, a certified EMT-1A or supervised EMT-1A trainee who has received appropriate training may monitor peripheral lines delivering intravenous fluids, Foley catheters, heparin locks, nasogastric tubes, and gastrotomy tubes under Section 10015(b), Title 22 of the California Health and Safety Code provided the following conditions are met:

1. An EMT-1A may monitor peripheral lines delivering intravenous fluids during interfacility transport and in the pre-hospital setting with the following restrictions:

Title: **Interfacility Transfer Guidelines**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Perinatal**
Source: Emergency Dept Nurse Manager	Effective Date:

a. The patient is noncritical and deemed stable by the transferring or base hospital physician and the physician approves transport by an EMT-1A, and,
b. No medication have been added to the intravenous fluids and,
c. In the pre-hospital setting, no other advanced life support procedures have been initiated.

2. The EMT-1A shall:
   a. Monitor and maintain the IV at a preset rate and,
   b. Check the tubing for kinks and reposition the arm if necessary when loss of flow occurs, and
   c. Check the tubing for kinks and reposition the arm if necessary when loss of flow occurs, and
   d. Turn off the flow of intravenous fluid if infiltration or alteration of flow occur. Vital signs should then be monitored frequently.
   e. Transfer patient with any combination/concentration of:
      1. D5/water with or without:
         a. normal saline
         b. lactated ringers
         c. Isolyte or Isolyte M
      2. Normal Saline
      3. Lactated Ringers

3. An EMT-1A may transport a patient with a heparin lock provided:
   a. The patient is noncritical and deemed stable by the transferring physician or Base Hospital physician and the physician approves the transport by an EMT-1A.
   b. The EMT-1A shall:
      1. Monitor the heparin lock only as placed at time of transfer and,
      2. Control any bleeding at insertion site.

4. An EMT-1A may transport a patient with a Foley catheter provided:
   a. The patient is noncritical and deemed stable by the transferring physician or Base Hospital physician and the physician approves the transport by an EMT-1A and,
   b. The catheter is able to drain freely to gravity and,
   c. No action is taken to impede flow or disrupt contents of drainage collection bag.

5. An EMT-1A may transport a patient with a nasogastric tube or gastrotomy tube provided:
   a. The patient is noncritical and deemed stable by the transferring physician or Base Hospital physician and the physician approves the transport by an EMT-1A and,
   b. Nasogastric and gastrotomy tubes are clamped and,
   c. All patients who have received fluids prior to transport should be transported to the closest receiving hospital.

For concerns of transfer of patients with DNR orders, see Section 13000 of the BLS (EMT-1A) pre-hospital manual found in the ER.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Interfacility Transfer Guidelines**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Perinatal**
Source: Emergency Dept Nurse Manager	Effective Date:

DOCUMENTATION:
Use appropriate forms to document care, ambulance run sheets or nursing notes as appropriate. Pre-hospital personnel responsible for following own documentation guidelines.

Reference: Title 22, H and S codes 10015(b) EMS Scope of Practice EMT-1A, EMT-II, and EMT-P and protocol manual.
Committee approval needed: Yes, Nurse Management
Responsibility for review and maintenance: E.D. Head Nurse
Index Listings: Ambulance Transfer Guidelines; Transfer, Ambulance Guidelines
Revised: 3/95; 02/01; 7/11as; 2/15as
Last Board of Director review: 6/19/19; 2/18/2020, 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Intubation Tray Adult/Pediatric**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Pediatric, Respiratory**
Source: Respiratory Therapy Director	Effective Date:

LOCATIONS: **Emergency Room Rm 1 and 7, ICU, PACU (Fiber Optic) Med/Surg, EKG, CT Control Room. (Standard)**

CONTENTS:

Endotracheal Tubes:	(2 each) 8.5, 8.0, 7.5, 7.0, 6.5, 6.0, 5.5, 5.0, and 4.5 Cuffed		
Oropharyngeal Airways:	(1 each) 60, 70, 80, 90,100mm		
Laryngoscope:	Two		
Laryngoscope Blades:	(at least 1 each)	Miller:	Adult 2, 3,4
		MacIntosh:	Adult 2, 3, 4
Stylet:	Adult (1 each) 14f—5.0 thru 10		
	10f—4.0 thru 6.0		
Forceps:	(1 pair) Adult McGill		

Batteries: appropriate size for laryngoscope

Syringe:	(1 12ml)
Oral mouth screw:	(one)
Endotracheal tube tapes:	(two)
Bite Block:	(one)

Responsibility for Review and Maintenance: Respiratory Therapy Dept
Index Listing: Pediatric Intubation Tray; Intubation Tray, Pediatric ; Intubation Tray, Adult; Adult/Pediatric Intubation Tray
Revised/Reviewed: 9-2012 kjc, 3-11-14 kjc
Last Board of Directors Review: 6/19/19; 10/16/19, 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Intubation Tray Infant**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Pediatric, Respiratory**
Source: Respiratory Therapy Director	Effective Date: 3-11-2014

LOCATIONS: Emergency Room Rm 1 and 7, ICU, PACU (Henie Fiber Optic)
Med/Surg, EKG, CT Control Room (Standard)

CONTENTS:

1. Endotracheal tubes, uncuffed, 2 each: 4.0; 3.5; 3.0; 2.5 Uncuffed
2. Laryngoscope with blades
   a. Miller: 00, 0, 1
3. Stylet: Pediatric 2.5 – 4.5
4. Oropharyngeal airways: 40mm, 50mm
5. Forceps: Pediatric Mc Gill, curved
6. Batteries; appropriate size for laryngoscope
7. Baby ET tape

Responsibility for Review and Maintenance: Respiratory Therapy Dept
Index Listing: Infant Intubation Tray; Intubation Tray, Infant
Revised/Reviewed: 1-07, 3-14 kjc
Last Board of Directors Review: 6/19/19; 10/16/19, 3/18/2020

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Iron Dextran (Imferon) Administration**	
Scope:	Department: **Emergency Dept, Medical/Surgical, Outpatient**
Source: Wagoner, Ann	Effective Date:

PURPOSE:

To establish guidelines for safe administration of iron dextran via intravenous route.

POLICY:

The physician will order iron dextran per this procedure unless otherwise indicated. Pharmacy calculates dose based on patient's current height and weight. Suggested uses (although not limited to the following) are: microcytic, hypochromic anemia; iron deficient patients in whom oral administration is infeasible or ineffective.

SPECIAL CONSIDERATIONS:

Physician Order required: __No, __X__Yes
Procedure may be performed by: __X__RN, ___LVN
Special education required to perform procedure: __No, __X__Yes - Familiarity with this medication
Age specific considerations: This policy is written with the adult patient in mind

EQUIPMENT:

IV start supplies
Normal Saline IV solution
Nitroglycerin IV tubing (pump tubing /no filter)
Multi-clave Extension
IV pump
Epinephrine 1:1,000

PRECAUTIONS:

Because anaphylactic reactions to Iron dextran have been reported, an initial test dose is recommended and epinephrine 1:1,000 and Benadryl 50mg IV and po should be immediately available. If an anaphylactic or acute hypersensitivity reaction occurs, dose and route of epinephrine administration will be determined by the physician. The usual dose of epinephrine 1:1,000 is 0.5 ml by subcutaneous or intramuscular injection, which may be repeated at 5 to 15 minute intervals. If necessary, 0.1 to 0.25 mg of epinephrine (1 to 2.5 ml of a 1:10,000 solution, prepared by diluting 1 ml of 1:1,000 epinephrine to 10 ml with normal saline), may be administered IV slowly and cautiously, over 5 to 10 minutes.

Iron dextran should be used with extreme caution in patients with serious hepatic impairment, rheumatoid arthritis and other inflammatory diseases.
Iron dextran should not be administered concomitantly with oral iron preparations.
Iron dextran should be diluted in 250 - 1,000 ml of Normal Saline. Dextrose solutions should not be used with Iron dextran because of increased incidence of phlebitis.

Do not mix with other medications.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Iron Dextran (Imferon) Administration**	
Scope:	Department: **Emergency Dept, Medical/Surgical, Outpatient**
Source: Wagoner, Ann	Effective Date:

PROCEDURE:

1. Explain procedure to the patient. (Obtain a consent only if physician requests one.)
2. Obtain current height and weight. Report to pharmacy.
3. Establish IV access, infuse normal saline at KVO rate. Need normal saline to flush in test dose over five minutes.
4. Premedicate as ordered (optional).
5. Administer test dose 1/2cc (25mg) IVP over five minutes.
6. Wait one hour, if no adverse reactions begin infusion per physician order (over 1 to 3 hours).
7. Call the physician for any problems. If anaphylactic reaction noted and ordering physician is not immediately available, the Emergency Room physician should be called.
8. Monitor vital signs every 15 minutes x 4 after test dose and at least hourly during administration.
9. Flush IV line with normal saline at the conclusion of the infusion.

DOCUMENTATION:

The procedure medication(s) administered and patient tolerance and vital signs should be documented by the RN on a "local anesthesia/special procedure" note or other appropriate nursing forms.

Committee approval needed: __No, __X__Yes Pharmacy Committee 6-18-98
and Nurse Management Committee
Responsibility for Review and Maintenance: PACU/OPD Nurse Manager and Director of Pharmacy
Index Listing: Iron Dextran Administration; Medication Administration, Iron Dextran
Revised: 3/98, 5/01, 4/02 AW, 02/04/04 CK,01/10 AW

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Latex Precautions	
Scope: Hospital Wide	Manual: Hospital Wide
Source: Surgery Nurse Manager	Effective Date: May 2000

PURPOSE:
To promote a safe health care environment for latex-sensitive, latex-allergic patients and health care workers. Northern Inyo Hospital and staff have an ethical responsibility to prevent latex sensitization in patients and employees by creating an environment in which it is safe to be treated and to work.

POLICY:
The goals of this policy are twofold:

1. to prevent initial sensitization in susceptible individuals, both patients and health care workers.
2. to prevent reactions in previously sensitized individuals.

A HOSPITAL WIDE latex-safe environment will be maintained. Devices and supplies with high latex protein content have been removed. Latex glove use has been discontinued with the exception of three different sterile surgical gloves (used by 3 surgeons at this time). In our integrated Hospital Information System these items are flagged as containing latex and appropriate substitutes are attached for the latex positive patient. The system automatically substitutes these items in surgery with a double check system in place performed by the circulation RN.

SPECIAL CONSIDERATIONS:

- People with a history of Type 1 allergic reactions to certain foods (bananas, papaya, avocados, kiwifruits, other stone fruits, tomatoes, raw potatoes, or chestnuts) have been shown to have an increased risk for latex sensitization.
- Individuals with occupational exposure to latex, and atopic individuals with a history of asthma, eczema, and rhinitis in reaction to medications and multiple environmental antigens are at risk for developing latex sensitization.
- Any individual who experiences any type of latex-associated reaction should be evaluated by a qualified health care practitioner.

Age specific considerations:

- Latex allergy is thought to be responsible for 70% of anaphylactic reactions occurring in anesthetized children.
- Children with spinabifida and myelodysplasia or a history of multiple surgeries beginning at an early age are at the highest risk for anaphylaxis.

Department specific considerations:

- The operating room and the obstetric department do carry physician-specific gloves with latex, as noted above. The gloves need to be removed for latex allergic individuals, so they will not be used inadvertently. The physician, as always for allergies, will be reminded of the patient's latex status.

PROCEDURE:

1. **First**: Be alert to potential allergy in high-risk patients. ALL patient assessments include an allergy assessment that includes Latex Allergy.
2. Potential employees are screened for latex allergy during the pre-employment physical. The appropriate nurse manager or department head is then notified of the allergy.
3. Identify latex-sensitized patients and those at risk to develop latex allergies.
    A. Instruct them about self-care, avoidance of latex products, Medical Alert Bracelet.
4. Ensure that the environment is free of contamination by latex. Environmental services will be notified to clean all surfaces that may have latex contamination.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Latex Precautions	
Scope: Hospital Wide	Manual: Hospital Wide
Source: Surgery Nurse Manager	Effective Date: May 2000

5. Post Latex Allergy signs. There should be signage on the patient's chart, patient room, and gurney for surgery when applicable.
6. Medications:
    A. If a medication needs to be given and has to be withdrawn from a rubber vial, consult with pharmacy. Whenever possible, medications should be used from a latex-free vial. When this is not possible, arrangements with the pharmacy should be made in advance so medications can be drawn into a latex-free delivery device under aseptic conditions (eg, inside the pharmacy's hood). If neither of these solutions is possible, the stopper should be removed and the medication withdrawn using a latex-free syringe. AORN does not recommend this practice unless all other options have been exhausted.
    B. For saline flushes use the 10ml pre-packaged latex free normal saline pre-filled syringes. Do not use the vials with rubber stoppers.
7. Use latex free supplies for anything that might come in contact with patient. Examples of products that have triggered reactions include gloves, anesthesia masks, tourniquets, electrocardiogram electrodes, adhesive tape, elastic bandages, condom catheters, rubber shoes, elastic in clothing, and balloons. Many products are labeled latex free; if in doubt don't use it.
    A. Avoid using oil or petroleum-based skin agents with latex products. These agents may cause breakdown of the latex product. Some skin care agents may help reduce glove-related problems and have been clinically formulated not to interfere with the glove's barrier integrity.
    B. Always check with the manufacturer of the skin care agent to verify that the chosen agent is latex compatible before putting the product into use.
8. Documentation:
    A. Document patient allergy and all precautions that you have taken in the patient notes specific for each unit.
    B. For employees, document in the appropriate work areas any specific precautions that have to be taken by the employee or by NIH staff.
9. Hospital Resource person to contact with any concerns or questions:
The Latex Resource RN is constantly looking for products that may have inadvertently come into the hospital with latex and these are removed. All staff members, every department, are encouraged to be checking their supplies for latex and reporting to the Latex Resource RN.
10. Testing for employees who believe they may have a latex allergy can be done free of charge. For testing contact Employee Health.

Important: The FDA standard requires all products that contain latex be labeled as such.

REFERENCES:
Perioperative Standards and Recommended Practices, 2011 edition, For Inpatient and Ambulatory Settings.

Responsibility for Review and Maintenance: Med/Surg & Surgery Nurse Managers
Index listings: Latex Precautions, Allergy Latex
Initiated: 5/00 VLaB/BS
Reviewed: 03/2006 BSS
Revised: 10/12/2011 LVB, BS; 9/12 LA
Last Board of Director review: 1/16/19; 6/19/19; 2/18/2020, 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer	
Scope: District	**Department:** District Wide
Source: Emergency Dept Nurse Manager	**Effective Date: 6/1/18**

PURPOSE:
To provide a process for when a patient leaves against medical advice or refuses a treatment or transfer.

POLICY:
An individual, except patients under police guard or an involuntary hold, has the right to leave the hospital against the advice of his physician. Any individual who has received treatment at NIH and then refuses further care or transfer will be informed of the benefits of further care versus the risk of no further care.

PROCEDURE:

A. If a patient, for any one of many reasons, desires to leave the hospital before his doctor thinks he is ready for discharge, refuses a certain treatment, test or intervention ordered, or transfer to another facility, every effort must be made to convince the patient to remain in this hospital or proceed with the tests/treatment or transfer.
    1. Notify physician of the situation
        a. The physician must attempt to provide the patient with information regarding the risks involved in leaving, benefits of continued stay in the hospital, and any other alternatives such as transfer to another facility or any other treatment.
    2. Patient's cause for discontent must be ascertained and solved if possible.
    3. Efforts should be also be made by the RN and shift supervisor to convince the patient to change his/her mind and all risks must be explained to the patient. This shall be well documented on the nurse's notes by the RN or shift supervisor.
    4. Patient's family and friends who may be concerned for his well-being should be enlisted to convince him to stay.
B. When all efforts have been made and the patient (or individual acting on their behalf) is still adamantly refusing further treatment and/or transfer and/or insists on leaving against medical advice, the informed refusal will be documented in writing on the appropriate form: (Available in English and Spanish)
    1. *Informed Consent to Refuse Treatment*
    2. *Leaving the Hospital Against Medical Advice*
    3. *Patient Refusal of Transfer*
C. No patient, other than patients under police guard or on involuntary psychiatric holds, can be forced physically to stay in the hospital against their will.
D. If a patient leaves undetected without signing the appropriate form, hospital staff should attempt to locate him/her and request that he/she return to the hospital so his /her signature may be secured on the form. Document all attempts and the results on the patient's chart.

E. Notify the following of AMA:
    1. Physician
    2. House Supervisor
    3. Department Manager
    4. Director of Nursing, if appropriate
    5. Police, if appropriate
    6. Administration, if appropriate
F. If all efforts to return the patient are unsuccessful and he/she cannot be located, document fully and precisely on nurse's notes and make out a Quality Review Report and turn in to Department Manager or House Supervisor.

Title: Leaving Hospital Against Medical Advice Refusal of Treatment or Transfer	
Scope: District	**Department:** District Wide
Source: Emergency Dept Nurse Manager	**Effective Date: 6/1/18**

G. Regardless of whether it is believed the patient will sign or not, the release form must be offered to the patient (or the parent or guardian) for signature in the presence of at least one witness. It is a requirement that this procedure is followed:
   1. If the patient (or parent/guardian) refuses to sign, proceed as follows:
      a. In the space provided for the patient's signature, write the words "***patient refuses to sign***." Beneath this line, sign your name and enter the exact time, date and a brief notation concerning the circumstances of the refusal.
      b. All hospital personnel who were present when the release was offered, and refused, must sign as witnesses to the refusal. Each witness must write his/her complete name - no initials.

REFERENCE:
1. California Hospital Association Consent Manual (2014), Ch. 5.5, Ch.9.2
2. California Code of Regulations Title 22 (2011), Article 70707, Patients' Rights

CROSS REFERENCE:
1. 28-03 Patients' Rights, Patients Responsibilities and Process for Resolution of Patient Grievances or Complaints.

Approval	**Date**
CCOC	1/29/18
Emergency Services Committee	3/14/18
Med. Services/ICU	4/26/18
Peri-Peds	2/23/18
Surgery /Tissue	4/25/18
MEC	5/7/18
Board of Directors	5/16/18
Last Board Review	3/18/2020

Revised/Reviewed: 12/96; 9/00; 2/01; 7/11as; 2/15as, 1/18 gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Legal Blood Alcohol Intake Form Completion of the**	
Scope:	Department: **Emergency Dept, Nursing Administration**
Source: Emergency Dept Nurse Manager	Effective Date: 12/07

Purpose:

The purpose of this policy is to insure compliance with EMTALA regulations by determining if a patient brought to Northern Inyo Hospital for forensic blood alcohol testing requires a medical screening exam. This policy will provide for observation and reasonable inquiry of a patient by a registered nurse to determine if a medical screening exam is required.

Policy:

The lab scientist will notify the supervisor upon the arrival of any patient brought directly to the lab by law enforcement for forensic testing of blood alcohol. The supervisor will be responsible for having an *Emergency Severity Index (ESI)* Triage -trained registered nurse go to the lab to complete the *Legal Blood Alcohol Intake Form.* The nurse completing the form may be a supervisor, an ED registered nurse, or another nurse who is cross-trained to the ED.

If any observations or responses prompt a medical screening exam, the nurse will request the law enforcement officer to escort the patient to the ED for triage, and an exam by an ED physician.

Procedure:

1. Lab scientist pages or calls the supervisor to notify him or her of a patient brought in for forensic alcohol blood levels.
2. The supervisor assigns an ESI triage trained nurse to complete the *Legal Blood Alcohol Intake Form (attached).* This can be:
    a. The supervisor
    b. An ED registered nurse
    c. A registered nurse trained competent in ESI 5-level triage
3. The form will be completed after speaking with the law enforcement officer, the patient and completing nursing observations.
4. If at any time in this process the nurse's observations or responses to the questions from the form indicate that a medical screening exam is required, the law enforcement officer will be asked to escort the patient to the ED to be examined by the ED physician.
5. The *Legal Blood Alcohol Intake Form* will be completed and kept in the ED office along with an accompanying log summarizing all encounters with patients brought to the NIH lab for forensic blood alcohol testing. (See attached)

Documentation:

The registered nurse will complete the *Legal Blood Alcohol Intake Form.* The completed form will be filed in the ED office filing cabinet. The supervisor will also maintain a *Legal Blood Alcohol Intake Form* log of all encounters with patients brought for forensic blood alcohol levels.

Committee approval needed ____ yes ____ no
Reviewed/Revised: 12/07; 7/11as; 2/15as
Last Board of Director review: 7/18/18; 6/19/19, 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Legal Blood Alcohol Intake Form Completion of the**	
Scope:	Department: **Emergency Dept, Nursing Administration**
Source: Emergency Dept Nurse Manager	Effective Date: 12/07

LEGAL BLOOD ALCOHOL INTAKE FORM

Date _____ Time _____

Name _____ DOB _____

Officer _____ Dept. _____ ☐ Verified Credentials

BLOCK 1 - - Obtain the following information from the officer:

1. Was there an accident involved	No	Yes	
IF YES…details:_____			
_____	CONSIDER MSE		
2. Was the individual thrown from a vehicle		No Yes	}
3. Did the individual lose consciousness at scene	No	Yes	} IF ANY
4. Was the individual trapped in the vehicle		No Yes	} YES
5. Did the individual complain of injury	No	Yes	} MSE IS
6. Was there a death in the individuals vehicle		No Yes	} REQUIRED
7. Did the individual state they are ill		No Yes	}
8. Did the individual strike the steering wheel		No Yes	}
9. Did the individual strike the windshield	No	Yes	}
10. Did the individual come in by ambulance		No Yes	}

BLOCK 2 - - Is the individual oriented to time, place and circumstances?

[ ] Yes [ ] No – You must provide MSE required

BLOCK 3 - - Obtain the following information from the individual:

1. Are you injured	No	Yes	}
2. Are you ill at this time	No	Yes	} IF ANY
3. Did you lose consciousness at any time today	No	Yes	} MSE IS
4. Do you suffer any pain at this time	No	Yes	} REQUIRED
5. Do you believe you need a medical exam or care at this time	No	Yes	}

BLOCK 4 – Nursing observation

1. Is there any observed bleeding	No	Yes	}
2. Is there any observed injury	No	Yes	} IF ANY
3. Is there any observed conduct or condition that may suggest a potential injury or illness	No	Yes	YES } MSE IS

NURSING SIGNATURE _____

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement	
Scope:	Manual: Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, PACU, Perinatal, Rural Health Clinic, Surgery
Source: OP/PACU Nurse Manager	Effective Date:

POLICY:
A licensed nurse who is qualified to use a local anesthetic prior to peripheral IV catheter placement may do so if the IV is ordered by a physician.

PURPOSE:
Infiltration anesthesia: Local anesthesia produced by injection of the anesthetic (lidocaine 1% plain) solution in the area of terminal nerve endings.

SPECIAL CONSIDERATIONS:
Physician order is: not required for the lidocaine.
Procedure may be performed by: X RN, X LVN
Special education required to perform procedure: X YES
The nurse will have:

- A current California nursing license.
- Successfully completed the probationary period.
- Successfully performed a return demonstration of this procedure.

SUPPLIES:
TB syringe w/ 25 gauge needle
30 gauge needle
Lidocaine 1%
IV Prep or alcohol pad
IV start supplies and IV as ordered

PRECAUTIONS:
Make sure that the patient is not allergic to lidocaine or any "caines" before initiating procedure.

PROCEDURE:
1. Explain the procedure to the patient. Gather supplies
2. Wipe top of lidocaine vial with the alcohol pad. Draw up most of a cc in a T.B. syringe. Change needle to a 30 gauge needle.
3. Select the peripheral IV site by tourniquet application, visual and manual inspection of extremity.
4. Wipe selected site with an IV prep pad.
5. Inject 0.1 to 0.2 cc of lidocaine intradermally, distal and to the side of the selected IV start site.
6. Gently massage the injection site for several seconds with a clean 2 X 2.
7. Reapply the tourniquet and proceed with the I.V. start according to the established guidelines.

DOCUMENTATION:
Document use of lidocaine (1%, intradermal) with IV start documentation on appropriate nursing form. (Document the number of IV start attempts.)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Lidocaine Anesthetic For Local Infiltration Prior To Peripheral Catheter Placement	
Scope:	Manual: Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, PACU, Perinatal, Rural Health Clinic, Surgery
Source: OP/PACU Nurse Manager	Effective Date:

Committee approval needed: ___ no __X__ yes: Nurse Management 10/98
Responsibility for review and maintenance: OPD/PACU Nurse Manager
Index listings: IV Therapy, Lidocaine for Peripheral Cath. Placement; Lidocaine Anesthetic, Local Infiltration, Peripheral Cath. Placement
Date revised: 9/98, 2/04, 8/25/04, 9/10/07, 9/08, 04/10AW, 05/11 AW, 09/12 AW
Last Board of Director review: 1/17/18; 1/16/19; 6/19/19; 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Medication Reconciliation	
Scope: Pharmacy & Nursing Staff	Manual: Medical Staff, Nursing All Unit, Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 2/1/18

PURPOSE:

To ensure timely and accurate medication information is captured and documented to compile a comprehensive list of the patient's medications.

- Communication of this information across the continuum of care
- To reduce medication-related errors
- Improve patient safety and outcomes.

POLICY:

1. The medication reconciliation process will include these steps:
    a. Obtaining and documenting the most complete and accurate list possible of all current medications for each patient.
    b. For the purposes of reconciliation, the term "medication" includes:
        - prescription medications
        - over-the-counter (OTC) medications
        - sample medications
        - investigational/study medications
        - vitamins and other supplements
        - herbal remedies
        - eye, ear, skin preparations or patches
        - dietary or nutritional supplements
        - parenteral nutrition
        - inhaled medications and respiratory treatments
        - diagnostic, contrast, and radioactive agents
        - vaccines
        - blood derivatives
        - intravenous solutions (plain, with electrolytes or drugs)
2. Comparing the list against admissions, transfer, and discharge orders.
3. Resolving any discrepancies.
4. Making necessary and appropriate medication changes based on the patient's clinical condition.
5. Communicating the complete and updated list to the next provider of service whenever the patient is referred or transferred to another setting, service, practitioner, or level of care within or outside the hospital.
    a. The medication reconciliation process shall be by the MD or Licensed Independent Practitioner at each of the following points-of-care:
        - NIH Clinics
        - ED
        - Admission

- Intra-hospital transfer to another service or level of care (i.e. ICU to floor transfer)
- Discharge to home or transfer to another facility

2. Qualified NIHD personnel include Registered Nurses (RN), and Pharmacists (RPh). One qualified personnel will review the home medication list entered into the EHR within 12 hours of a patient's admission to the hospital as an inpatient or observation patient.
3. The qualified personnel will interview the patient and/or family member or caregiver to ascertain the most accurate home medication list including doses and times of administration.
4. The qualified personnel will verify or research when necessary the most accurate information by contacting the patient's provider, pharmacy, or family. The qualified personnel will consult with a pharmacist if assistance is needed.
5. The qualified personnel will correct any entries in the Home Medication list made by previous entering personnel.
6. The physician will make every effort to review and reconcile the medication list using the Medication Reconciliation Module of the Computerized Physician Order Entry system in Paragon prior to entering new orders.
7. As part of the discharge process, the physician will utilize the Medication Reconciliation Module to reconcile discharge medications.
8. Qualified personnel shall print the Discharge Summary and Discharge Medication Reconciliation and educate patient or report to another facility. The Discharge Medication Reconciliation Summary is given to the patient at discharge.

Procedure:

1. Obtain information to complete the list of the patient's current medications and document this information in the electronic health record (EHR). Information sources may include:
    a. Prescription medications
    b. List provided by the patient or surrogate
    c. Patient/family recall
    d. Primary care physician or other medical service providers
    e. Medication Administration Record (MAR) from an outside facility or agency
    f. Discharge summary or discharge medication list from a previous hospitalization (providers are discouraged from using a recent discharge summary as the sole data source)
    g. Current hospitalization MAR
    h. Contacting patient's provider, family, or pharmacy.
2. Reasonable efforts should be made and resources used to obtain medication information in situations involving a poor historian; literacy, language, cultural, or cognitive status barrier; or other patient vulnerability.
3. A complete medication entry will include the elements listed below, if unable to obtain this information, the nurse or pharmacist will document the reason:

Title: Medication Reconciliation	
Scope: Pharmacy & Nursing Staff	Manual: Medical Staff, Nursing All Unit, Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 2/1/18

   a. Medication or product name
   b. Dose (including concentration for liquid medications—e.g. mg/mL)
   c. Route or site of administration
   d. Frequency (schedule)
   e. Date and time of last dose
   f. Reason or indication for use
4. The discharging physician shall review the admission Medication Reconciliation History prior to placing discharge orders.
5. The patient or caregiver should be given a copy of the Discharge Medication Reconciliation Summary at the time of discharge and encouraged to partner with medical providers in keeping the list current.
6. The patient should not need to be contacted more than two times to discuss their home medications during the admission process. First, the medication verification process will be conducted by either the pharmacy technician, registered nurse, or pharmacist. Second, the medication reconciliation discussion will ideally occur during the provider's initial assessment of the patient.

References:

1. The Joint Commission Chapter: National Patient Safety Goals Standard: NPSG.03.06.01: Maintain and communicate accurate patient medication Goal 3, Improve the safety of using medications
2. The Joint Commission Chapter: Provision of Care, Treatment and Services: PC.01.02.03: CAH defines, in writing, the time frame(s) within which it conducts the patient's initial assessment.
3. ASHP Policy: 0620: PHARMACISTS' ROLE IN MEDICATION RECONCILIATION Source: Council on Professional Affairs

Cross Reference P&P:

1. Medication Reconciliation
2. Admission, discharge, Transfer of Patients: Continuum of Care

Committee Approval	Date
Clinical Consistency	4/23/18
Pharmacy and Therapeutics Committee	7/5/18
Medical Executive Committee	7/9/18
Board of Directors	7/18/18
Last Board of Directors Review	3/18/2020

Developed: 4/9/15
Reviewed:

Title: **Medications Emergency Department**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date: 12/15/2004

PURPOSE:

To define the circumstances and process for physician dispensing in the ED as well as the storage, procurement and administration of medications

POLICY:

Storage:

1. The Emergency Department maintains a supply of medications approved by the Pharmacy/Therapeutics Committee and the Emergency Room Committee.
2. These drugs shall be maintained in a manner, which assures product integrity and prevents access by unauthorized persons.
3. All medications will be stored in the automated dispensing machine, or the refrigerator/freezer as is appropriate to the drug. Internal and external medications will be stored separately per the medication storage policy in pharmacy.
4. Vials will be discarded by the expiration date suggested by manufacturer after reconstitution or entry.
    a. ALL VIALS will be dated and initialed when opened, unless discarded immediately after a single dose has been withdrawn. If reconstituted, the vial will be labeled with the concentration and the manufacturer's suggested expiration date, if applicable.
    b. Single dose vials will be for a single patient use only. Provided it has been dated and initialed, and unless contraindicated by stability, a single use vial may be used, for a single patient, for the duration of the patient's stay in the ER,.
    c. Multiple dose vials (i.e., containing bacteriostatic agent) are considered single patient vials. A multiple dose vial may be used until the patient has been discharged from the ER visit. The vial must be dated and initialed at the time of opening.
    d. Skin test materials and vaccines containing preservatives may be used for multiple patients and kept until the manufacturer's expiration date, provided the vial has been dated and initialed.
    e. Opened, undated, unlabeled, not-initialed vials will be discarded immediately without use. Discarded medications will be discarded in the sharps container or in a container designated specifically for this purpose.
    f. Discontinued and outdated drugs, and containers with worn, illegible, or missing labels will be returned to pharmacy for proper disposal. Pharmacy will check the drug supply in accordance with pharmacy policy.
    g. Sterile irrigating solutions of Sodium Chloride, Sterile Water, and physiologic solutions will be dated and initialed when opened and discarded after 24 hours.
    h. Nitroglycerin tablets shall be dated when first opened and discarded one month after opening.

Dispensing:

1. A physician may only dispense take-home drugs if no pharmacist is available in the hospital.
2. A physician may only dispense medications pre-packaged by the pharmacy.
3. The physician providing the medication to the patient must label the package.

Title: **Medications Emergency Department**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date: 12/15/2004

4. The label must contain the date, name and strength of the medication, quantity of drug, instructions for use, the patient's name, the expiration date and the physician's name.
5. The physician must place their initials on the label.

Prescribing:

1. Prescriptions should be written on a prescription pad by the treating physician and given to the patient.
2. Prescriptions may also be telephoned to outside pharmacies by the physician, or by the nurse if the physician has written the order on the chart or on a prescription for the patient.
3. The patient must make the choice of the pharmacy.
4. A physician who is a member of the hospital medical staff may order medications that are included in the hospital formulary for administration to patients.
5. Orders for medications must be written on a hospital order sheet.
6. The physician may also give a verbal or telephone order to a licensed nurse in accordance with the Verbal Orders Policy. The ordering physician must sign verbal orders within 48 hours.

Procuring:

1. Emergency Department Staff should check stock medications daily and reorder needed medications from the pharmacy.
2. During hospital pharmacy hours, non-stock drugs are ordered directly from the hospital pharmacy.
3. After pharmacy hours, the Nursing Supervisor, in accordance with the pharmacy Night Locker policy will obtain non-stock medications.
4. Neither the ED nor the hospital pharmacy will restock medications utilized in the pre-hospital setting (ambulances) for emergency department patients.

DOCUMENTATION:
All medications administered or dispensed must be properly documented in ER records under treatments/medications/infusions section of the chart.

Committee Approval	Date
Policy and Procedure Committee	2/19/04
Pharmacy and Therapeutics Committee	2/19/04
Emergency Services	3/24/04
Medical Executive Committee	12/15/04
Administration	12/15/04
Board of Directors	12/15/04
Last Board of Director review	6/19/19

Revised 02/17/04
Supersedes 2/02; 6/11as; 2/15as

Responsible for Review: Emergency Department Manager
Index Listings: Emergency Department Medication

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Mentally Ill Patients Detention of**	
Scope:	Department: **Emergency Dept, Social Services**
Source: Emergency Dept Nurse Manager	Effective Date:

POLICY:

To provide guidelines for acute care hospitals to detain mentally ill patients without their consent for up to eight hours while arranging for a transfer to an appropriate facility, and provide immunity from liability.

SPECIAL CONSIDERATIONS:

Physician order is required.
To staff and physicians:
1799.111 (a) A licensed general acute care hospital, as defined by subdivision (a) Section 1250, provides that a licensed general care hospital, licensed professional staff of the hospital, or any physician and surgeon, providing emergency medical services to a person at the hospital, shall not be civilly or criminally liable for detaining a person, or for the actions of the person after release from the hospital, if all of the following conditions exist:

1. The person cannot be safely released from the hospital because, in the opinion of the treating physician, surgeon, or a clinical psychologist with the medical staff privileges, clinical privileges or professional responsibilities provided in Section 1316.5, the person, as a result of a mental disorder, presents a danger to himself or herself, or others, or is gravely disabled. "Gravely disabled" is defined, for the purpose of this law, as an inability to provide for his or her basic personal needs of food, clothing, or shelter.
2. The hospital staff or treating physician, surgeon or appropriate licensed mental health professional have made, and documented, repeated unsuccessful efforts to find appropriate mental health treatment for the person.
3. The person is not detained beyond eight hours.

This law does not solve the problem of what to do with a patient who cannot be transferred to a "5150-designated" facility within the eight hour maximum detention period. In addition, this law provides no definition of "mental disorder" or guidance as to when the clock starts running on the maximum eight hour detention period (for example, when the patient enters the emergency room? When the patient sees the treating physician? Etc.) Finally the law is not clear about what is meant by "find(ing) appropriate mental health treatment" for a patient. (The intent of the drafters and supporters of the bill was to provide immunity for detaining a patient while arranging for a transfer to a facility designated by the county to involuntarily hold mentally ill patients.)

PRECAUTIONS:

This law does not affect the responsibility of a hospital to comply with all state laws and regulations pertaining to the use of seclusion and restraint and psychiatric medications for
psychiatric patients, In addition, patients detained under this law retain their legal rights regarding consent for medical treatment. In other words, the hospital cannot treat the patient without his or her consent, or the consent of the legal representative if the patient has been determined by a physician to lack capacity to consent to treatment.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Mentally Ill Patients Detention of**	
Scope:	Department: **Emergency Dept, Social Services**
Source: Emergency Dept Nurse Manager	Effective Date:

DOCUMENTATION:

Detention of patient pursuant to health and safety code section 1799.111 - Certification of Physician Form must be completed, and repeated attempted efforts to find appropriate mental health treatment for the patient made.

Reference: California Health & Safety Code 1799.111
Committee approval needed: No
Responsibility for review and maintenance: ER Head Nurse, Social Services
Index Listings: Detention of Mentally Ill Patients; Mentally Ill Patients; 5150 Detention
Initiated/Revised: 2/98; 7/2000, 03/09/04 MR; 2/15as
Last Board of Director review: 7/18/18; 6/19/19, 4/15/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: MICN Guidelines	
Scope: Emergency Department	Manual: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 10/23/17

PURPOSE:
To allow the MICN to give immediate direction by radio to the Advanced Life Support (ALS) provider following the protocols as set forth by the California State Emergency Medical Authority (EMS), administered locally by the Inland Counties Emergency Medical Agency (ICEMA), and approved as described by ICEMA.

POLICY:
The ALS providers are responsible for giving a patient care report for any patient contact. The MICN on duty at Northern Inyo Hospital emergency department (ED) shall have the necessary authority to give direction to the ALS providers by radio as outlined in the protocols. This policy allows that the MICN at Northern Inyo Hospital will have the necessary authority to follow current protocols as outlined by this policy to give direction to the ALS providers by radio.

The emergency department nurse manager, pre-hospital liaison nurse (PLN) and the base station hospital director (BSD) or designee will review the protocols prior to being instituted. If the BSD, or ED physician has concern over a particular protocol that issue will be addressed in the Emergency Room Committee, and the committees decision will be forwarded to ICEMA. If agreed upon, that concern will be noted as an exception to the protocols for the MICN to follow. This exception will be placed in the appropriate place in the protocol book for direction in the ED, and all MICN's will be notified and any exceptions will also be noted in the protocol manual.

PROCEDURE:
MICN's will have current understanding of approved protocols and will refer to the protocol manual located in the ED when any question about protocol direction arises. All MICNs will complete the requirements for MICN certification or recertification. The protocol manual will be updated as new protocols are approved, and a copy of the current protocols will be available in the main ED, near the radio at all times. This book will be updated as protocols and exceptions to protocols are made.

DOCUMENTATION:
MICN shall document all ALS contacts on the MICN run sheet and pre-hospital log. The MICN shall also be responsible for any other pertinent paperwork relating to ICEMA policy.

REFERENCE: LALS/ALS ICEMA (EMS Agency) Protocol, Base Hospital Designation, Health and Safety Code Division 2.5 1797.56

Approval	**Date**
CCOC	8/28/17
Emergency Services Committee	9/13/17
Medical Executive Committee	10/3/17
Board of Directors	10/18/17
Last Board of Director Review	6/19/19

Initiated: 2/95
Revised: 3/00 BB; 12/03 MR, 09/07 AS
Reviewed:
Responsibility for review and maintenance: ED Nurse Manager; PLN or Designee
Index Listings: MICN Standing Orders

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Myocardial Perfusion Stress Test: Nuclear**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Outpatient, PACU, Rural Health Clinic**
Source: Wagoner, Ann	Effective Date:

PURPOSE:

To define Myocardial Nuclear Perfusion Stress Test policies and procedures.

POLICY:

1. The NIH EKG department will coordinate and schedule all Myocardial Nuclear Perfusion Stress Tests.
2. The Physician, medical office personnel, Emergency Department, or clinic will contact EKG department to coordinate and schedule the test.
3. EKG department will coordinate with the Outpatient unit to insert an IV and with NUCLEAR MEDICINE to inject the SESTAMIBI and do nuclear studies.
4. EKG will schedule the patient for the test when all departments are available and able to perform the test
5. An EKG technician will give patients the pre test instructions and obtain a list of medications the patient uses and allergy history.
6. The patient will check in at the C-Floor Registration Desk.
7. The EKG department will obtain informed consent.
8. EKG department will prepare the patient for a stress test in the standard manner.
9. A nurse from the Outpatient Department will start a bifurcated saline lock if possible. The left arm will be used for saline lock placement due to the positioning in Nuclear medicine unless the patient is unable to raise the left arm above his/her head. If the Outpatient Department is not available, the shift supervisor will be notified to find or provide nursing coverage
10. Once the patient is prepared, the Supervising physician will be notified and will be present before and during the test, and during the recovery period of the stress test portion.
11. While the patient is still in the EKG department, a Nuclear Medicine Tech will give the Sestamibi injection (which had been drawn up in the Nuclear Medicine Department for the procedure) through the saline lock.
12. Once the stress test is complete, the patient will be taken to Nuclear Medicine for the scanning portion of the procedure.
13. Once the patient is transferred to the Nuclear Medicine department, the patient will be under the care of the Nuclear Medicine Department exclusively.

PROCEDURE:

1. A Nuclear Medicine Tech will be present in EKG at the start of the exercise testing. The Sestamibi will be drawn up ready for injection. Unless the patient already has a saline lock in place, a nurse (usually from Outpatient) will start a saline lock – preferably in the left arm.
2. An appropriate stress testing protocol will be selected and the patient will begin walking on the treadmill.
3. When the patient reaches 85-90% of the predicted maximal heart rate and is able to continue for another 30-60 seconds, the Nuclear Medicine Tech will inject the Sestamibi into the saline lock and flush the line with saline.

Title: **Myocardial Perfusion Stress Test: Nuclear**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Outpatient, PACU, Rural Health Clinic**
Source: Wagoner, Ann	Effective Date:

4. The patient will continue to walk for 30-60 seconds then the treadmill will be slowed and stopped as per standard stress test protocol.
5. The patient will be monitored during the post exercise period as per standard protocol. The saline lock will be left in place – the nuclear medicine technician will remove and discard the saline lock after the scan or the next day after a resting scan has been, done if indicated.
6. When the patient has recovered from the stress portion of the procedure the patient may be given some water to drink to provide contrast for the scan.
7. The attending physician will assess the patient. If any unusual or prolonged side effects occur the attending physician will treat the patient if indicated.
8. The patient will be transported to Nuclear Medicine for the scan – this is the building directly behind the A-floor report room. At the time of transfer the patient will be under the care of the Nuclear Medicine Department.
9. If a resting Sestamibi scan is needed, the Nuclear Medicine Department will schedule this with the patient.

DOCUMENTATION: A brief patient assessment and the saline lock start will be documented on the Nuclear Stress Test sheet. The EKG and Nuclear Medicine Departments may also document on this form.

Index Listings: Nuclear Stress Testing; Stress Testing, Nuclear Perfusion; Myocardial Perfusion Stress Test

Committee Approval	**Date**
Pharmacy Committee	4/20/03
Policy and Procedure Committee	12/18/03
Medical Services Committee	2/10/04
Radiology Committee	3/2/04
Medical Executive Committee	3/11/04
Administrator	3/15/04

Revised 3/27/03,
4/3/03,
4/17/03,
8/26/03
12/03
Reviewed
Supercedes 8/03

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Myocardial Perfusion Stress Test: Nuclear**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Outpatient, PACU, Rural Health Clinic**
Source: Wagoner, Ann	Effective Date:

INDICATIONS: (From ACC/AHA guidelines for the use of exercise myocardial perfusion imaging – Amer. Coll. Cardio 25:521-547, 1995)

1. Prognostic stratification after AMI.
2. Identification of ischemia in patients with unstable angina.
3. Identification and extent/severity of ischemia in symptomatic patients and selected patients with asymptomatic myocardial ischemia.
4. Risk stratification for selected patients before non-cardiac surgery.
5. Assessment of ischemia in symptomatic patients after CABG, PTCA, and stenting.
6. Abnormal stress test (Not nuclear perfusion test).

CONTRAINDICATIONS:

1. Acute myocardial infarction
2. Unstable angina
3. Life-threatening arrhythmia
4. Acute cardiac inflammation
5. Critical aortic stenosis
6. Congestive heart failure
7. Pulmonary emboli
8. Significant uncontrolled hypertension
9. Serious non-cardiac diseases
10. Unwilling patient or patient unable to give informed consent
11. Patient unable to walk on treadmill

ADVERSE REACTION TO TECHNETIUM-99M

1. Headache
2. Metallic taste /Change in smell

EQUIPMENT

1. Treadmill, EKG
2. IV start supplies, saline lock
3. Chair and bed
4. Oxygen and cannula or mask
5. Oximeter
6. Crash cart and suction

MEDICATION USED IN TEST

1. Technetium-99m (Sestamibi, Cardiolite)
2. Normal saline for saline lock flush

Title: **Myocardial Perfusion Stress Test: Nuclear**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Outpatient, PACU, Rural Health Clinic**
Source: Wagoner, Ann	Effective Date:

PATIENT INSTRUCTIONS: To be given to the patient by the EKG Department when scheduling the test:

1. No CAFFEINE, such as coffee, tea, soft drinks with caffeine, chocolate, or medications with caffeine for 24 hours prior to the test
2. NPO for at least 4 hours prior to the test.
3. No BETA BLOCKERS for at least 24 hours prior to the test if approved by the patient's physician. If beta blockers are being used to treat atrial fibrillation then the beta blocker should not be held. The patient's primary physician will instruct the patient if the beta blocker medication should be held for testing purposes.
4. The patient should wear comfortable 2 piece clothing (pants/shirt) without metal buttons, no necklaces, chains or jewelry around the neck or chest. Women should be informed not to wear underwire bras. The patient should wear comfortable walking shoes.

PRECAUTIONS FOR PERSONNEL: All personnel involved with patient care while patient receives the Technetium-99m (Sestamibi or Cardiolite) should wear a Radiation Detection Badge.

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Neupogen / Procrit Administration	
Scope:	Manual: Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical
Source: OP Nurse Manager	Effective Date:

PURPOSE: To outline the procedure used in the administration, teaching, documentation, and charging of the two biologic response modifiers:1) Neupogen: filgrastim (granulocyte colony-stimulating factor; G-CSF) which is given to stimulate WBC production and 2) Procrit (Epogen): epoetin alfa (erythropoietin), which is given to stimulate RBC production.

POLICY: Neupogen and Procrit are ordered by a health care practitioner. The health care practitioner must have enrolled in the ESA Apprise Oncology Program to order Procrit for patients being treated for cancer.
Both medications are given as a subcutaneous injection.
Neupogen stimulates the production of white blood cells. Consideration for administration is generally based on absolute neutrophil count (ANC) otherwise known as total PMNs.
Procrit stimulates the production of red blood cells. Consideration for administration is generally based on hematocrit values. Some patients may require supplemental iron.

SPECIAL CONSIDERATIONS:
Physician order: required
Procedure may be performed by: __x__ RN or __x__ LVN
Special education required to perform procedure: ____no _x_ yes: familiarity with specific side effects, contraindications, and doses for each drug as well as familiarity with giving subcutaneous medications.
Age specific considerations: Children will need smaller doses. Check the doctor's orders for the dose.
Special Education required for Health Care Practitioners: Required education and enrollment in the ESA Apprise Oncology Program to order Procrit for cancer patients.

EQUIPMENT:
1) Appropriate equipment to monitor vital signs: temperature for Neupogen administration; temperature, blood pressure, pulse, and respiration for Procrit administration
2) Syringe (3cc) with needle, 30 gauge needle, alcohol swab, bandaid

PRECAUTIONS: It is best to try to keep the Neupogen injections approximately 24 hours apart (varying up to 6 hours either way is acceptable according to the manufacturer): Procrit can be given weekly as needed depending on Hemoglobin/Hematocrit.

PROCEDURE: Neupogen and Procrit are administered by subcutaneous injection.
Scheduling: The OPD will be responsible for the administration of these medications during regular Outpatient Department hours (generally week days). The supervisor should receive the orders when the Outpatient Department is not open and make a nursing assignment based on staff and patient load at the time.
1. Check the order. Give a copy to pharmacy.
2. If the physician has not written the lab values in the orders, obtain a copy of the CBC to go with the chart.
3. Obtain the medication from Pharmacy.
4. Warm the vial of medication in the palm of your hand. **DO NOT SHAKE THE VIAL**
5. Draw up the medication, change the needle to the 30gauge needle after getting the air bubbles out.
6. Give the medication per subcutaneous route/procedure. Use the upper arms.
7. Document and charge as outlined below.

Title: Neupogen / Procrit Administration	
Scope:	Manual: Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical
Source: OP Nurse Manager	Effective Date:

8. Teaching: There is a patient handout for each of these medications. Photocopy and distribute to each patient receiving either Neupogen or Procrit for the first time.
   The nurse should be familiar with the side effects.

   Potential Neupogen side effects: medullary bone pain (mild to moderate, usually relieved with acetaminophen or ibuprofen), flu-like aching, and transient hypotension that does not require treatment.
   Potential Procrit side effects: hypertension, headache, tachycardia, nausea and vomiting, clotted vascular access, shortness of breath, hyperkalemia, diarrhea, flu-like symptoms

DOCUMENTATION: Use the OP Short Procedure Form. The appropriate parts of this sheet should be filled in: the top section, a brief description of the procedure, vital signs as appropriate (temperature for Neupogen, and blood pressure, pulse, and respiration for Procrit). The top white sheet will go to Medical Records and the bottom (yellow) sheet will go to the OP clerk. The clerk will use the information for charging and logging the patient.

Committee(s) approval needed: ____no _x_ yes: Nurse Management
Responsibility for Review and Maintenance: OPD Head Nurse
Index Listings: Neupogen Administration, Epogen Administration, Filgrastim Administration, Procrit Administration
Revised: (or initiated): 11-97, 11-09
Reviewed: 02/01, 1/10AW, 4/10AW, 05/11AW, 09/12 AW
Last Board of Director review: 1/17/18; 1/16/19; 6/19/19, 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: NPO Guidelines	
Scope:	Manual: Anesthesia, Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Surgery
Source: Surgery Nurse Manager	Effective Date:

PUROSE: To outline suggested preoperative and pre-procedure NPO times.

POLICY:

- All patients scheduled for elective surgeries or procedures with anesthesia and / or conscious sedation other than local anesthesia should be NPO according to the schedule below.
- In emergency situations the NPO status will be evaluated by the physician administering the anesthesia/sedation and should be considered in determining appropriate technique.

SPEICAL CONSIDERATIONS:

Physician Order required: _X_ No, ___Yes
Procedure may be performed by: _X_RN, _X_LVN
Special education required to perform procedure : _X_ No, ___Yes
Age specific considerations: Refer to NPO Guideline Table for children.

EQUIPMENT: N/A

PRECAUTIONS: NPO status must be taken into consideration during conscious sedation due to the potential loss of airway protective reflexes and risk of vomiting/aspiration.

PROCEDURE: Suggested number hours patient should be NPO:

Patient's Age	Number of hours since solid food / milk / breast milk	Number of hours since clear liquids
< 6 months	4	2
6 – 36 months	6	3
> 36 months – adult	6 – 8	2

DOCUMENTATION:

Committee approval needed: __ No, _X__Yes Surgery Tissue Committee 1-25-2012
Responsibility for Review and Maintenance: Surgery and OPD/PACU Nurse Managers
Index Listing: NPO Guidelines; Guidelines, NPO; Instructions – Perioperative Pediatric Feeding; NPO Instructions
Initiated:01/29/01
Revised: 02/13/01, 3/11 TS BS
Last Board of Director review: 1/17/18; 1/16/19; 6/19/19, 3/18/2020

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Nursing Care of Outpatient Interventional Radiology Patient	
Scope: OPD Nursing and Radiology	Manual: NURSING, PACU
Source: DON Perioperative Services	Effective Date: 11/17/17

PURPOSE:
This general nursing policy outlines the procedures for monitoring, observing, assisting, medicating and supplies needed for nursing care of patients having interventional radiology procedures. The Procedural Sedation policy will be followed for any patient receiving sedation during the procedure. Each patient will receive the teaching needed to undergo the procedure, the care ordered by the Radiologist, and discharge instructions will be reviewed with and given to the patient prior to discharge.

The patient will be under the care of the Radiologist and will be monitored and cared for by an RN competent in:

- Basic arrhythmia recognition
- Airway management
- Cardiopulmonary resuscitation
- Clinical pharmacology sedative/analgesic medication used and their antagonists.
- Knowledge of the equipment utilized for patient monitoring
- ACLS certified

PRE-PROCEDURE PHONE CALL / ASSESSMENT

- Patients scheduled for an RFA or Vertebroplasty will be called by an RN to obtain information for the patient profile (including allergies and regular medications), and to give the patient information re: upcoming procedures including arrival time, check in area, and to ensure the patient has arranged for a ride home with a responsible adult after the procedure.
- Check orders to ensure any pre-procedure testing has been completed and if sedation is ordered – that Pharmacy receives a copy of the orders.
- Verify that lab results (PT, PTT, bleeding time, and any other ordered lab work) are on the chart and any abnormal values have been reported to the ordering physician

PRIOR TO PROCEDURE:

- Verify that a signed consent is on the chart
- Patient will change into a gown and a set of vital signs and a brief patient assessment should be completed by one of the Outpatient nurses when patient arrives for the procedure.
- IV catheter 22g or greater will be placed for all sedation patients.

ASSESSMENT:
The RN should complete a pre-procedure assessment with documentation on a checklist to include:

Title: Nursing Care of Outpatient Interventional Radiology Patient	
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- Patient identified using 2 patient identifiers (Name and DOB)
- Physical assessment
- Allergies
- Current medications
- Baseline vital signs, including oxygen saturation and pre-procedure Aldrete Score
- Level of Consciousness, age, and weight
- Current medical problems
- Patient education needs, abilities, preferences and readiness to learn
- Pregnancy status
- Verification that a responsible adult is available to transport the outpatient home.

DOCUMENTATION:
Nursing care should be documented in the EHR. The sedation (medication administered, vital signs and assessment during the procedure) should be charted on the Outpatient Procedure/Local Anesthesia Record.

Care Guidelines for the following procedures are included below:
- **RFA**
- **Vertebroplasty**
- **Observation of the Lung or Liver Biopsy**
- **Observation Following a Myelogram**
- **Monitoring the Patient in the MRI Unit**
- **Anxiolysis in the MRI Unit**
- **VCUG: Assisting with a Voiding Cystourethrogram**

Nursing Care of Outpatient Interventional Radiology Patient):
These patients generally receive procedural sedation

CONTRAINDICATIONS:
1. Absolute
   - Bacterial infection: systemic or localized at the injection site
2. Relative
   - Allergy to injectants
   - NSAIDs, aspirin, or other antiplatelet agents (ex. Plavix, Coumadin, Lovenox, Gingko Biloba)
   - Hyperglycemia, adrenal suppression, immune compromise, congestive heart failure
   - Pregnancy
   - Bleeding diathesis: due to anticoagulants or hematologic disease

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COMPLICATIONS: include, but not limited to:

1. Infection (cellulitis, osteomyelitis)
2. Bleeding
3. Cardiovascular (dysrhythmias, congestive heart failure, vasovagal reaction)
4. Respiratory
5. Urologic
6. Neurologic Injury (neuritis)
7. Adverse local anesthetic drug reaction
8. Adverse steroid reaction
9. Allergic reaction to non-ionic contrast

Potential post-procedural complaints include, but are not limited to:

1. Vasovagal reaction
2. Pain (injection site, radicular, corticosteroid flare)
3. Headache
4. Numbness or weakness
5. Burning/tingling in distribution of nerves adjacent to treatment area

PRE-PROCEDURE SCREENING

1. Identify food and drug allergies at the time of scheduling procedure.
2. Identify medications and compounds affecting clotting mechanisms, coordinate medication hold with referring or prescribing physician.

Medication or compound	**Days to hold before procedure**, at radiologist's discretion
Non-steroidal anti-inflammatory drugs	3 days
Coumadin (warfarin)	6 days
Ticlid	14 days
Plavix	10 days
Pletal and Trental	2 days
Persantine and Aggrenox	7 days
Heparin, Lovenox, Innohep, Fragmin, Normiflo	12 hours

PROCEDURE:

1. Radiologist to explain the procedure to the patient and answer any questions.
2. Patient signs consent form for procedure.
3. Prior to the start of a procedure, a time out should be performed (see Universal Protocol).

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4. Assess the patient's pain level.
5. Place the patient prone on the c-arm table with a pillow under the pelvis, if desired. Radiologist performs the procedure.

POST PROCEDURE:

1. After the procedure assess the patient carefully when helping them off the table, observing for extremity numbness or other complications.
2. OP observation for 1 - 1.5 hours.

VERTEBROPLASTY:

The percutaneous application of an acrylic based cement to the vertebral body for the purpose of stabilizing a fracture or other disruption of the vertebral body. These patients generally receive procedural sedation.

INDICATIONS: Acute compression fracture related to osteopenia or neoplastic replacement, ie pathologic fracture

CONTRAINDICATIONS: Spinal stenosis, traumatic fracture in young patient, very displaced fracture fragments

PATIENT PREPARATION:

1. The patient will be instructed to arrive one hour prior to the scheduled time of the procedure.
2. Following admission, the patient will go to outpatient nursing for assessment and IV insertion.
3. Medical history to include current medications, allergies and concurrent conditions will be reviewed or obtained. Lab results will be reviewed by nursing. Any lab results outside of the expected range will be reviewed with the radiologist.
4. Nursing will complete a basic physical assessment to include heart and lung status and vital signs including blood pressure, pulse, respirations and O2 saturation on room air.
5. Informed consent shall be obtained.
6. An IV will be started by nursing. An IV solution will be ordered by the radiologist and will be run at a TKO rate
7. Review of procedure and post procedure routines will be reviewed with patient. Post-procedure teaching to include recovery positioning.

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PROCEDURE:

1. Patient will be taken to the restroom immediately prior to procedure.
2. Patient will be taken into prepared procedure room.
3. O2 nasal cannula will be placed on patient prior to positioning on the imaging table.
4. Technologist will position patient prone on procedure table.
5. NIBP, O2 saturation monitoring will be established by nurse.
6. Once entire procedure team is in the room, TIMEOUT shall take place. TIMEOUT will be documented per hospital policy (Universal Protocol).
7. The nurse will begin sedation as directed by radiologist in compliance with the hospital Procedural Sedation policy. Vital signs will be monitored at a minimum of every 5 minutes throughout procedure.

POST PROCEDURE:

1. Sterile dressing and Tegaderm® (or equivalent product) will be applied to bilateral needle puncture sites.
2. Patient to remain in prone position on procedure table for a minimum of 15 minutes before transfer back to recovery gurney.
3. Patient to be transferred to supine position on recovery gurney. Pillows may be placed beneath knees as needed for comfort. Patient to remain in supine position for 2 hours.
4. Vital signs to be monitored per Procedural Sedation policy then every 30 minutes X 2.
5. Patient may begin oral fluids once fully awake.
6. Head of Bed may be elevated after 2 hours as tolerated. Patient may ambulate as tolerated.
7. Patient may be discharged once 2 hours time has elapsed and patient is stable.
8. Discharge instructions to include removal of dressing, ice instead of heat and follow up appointment with radiologist in 2 weeks.
9. If vital signs are significantly different than baseline or if there is excessive drainage on dressings, notify radiologist prior to discharge.

OBSERVATION OF THE OUTPATIENT LUNG OR LIVER BIOPSY

The "Procedural Sedation" policy will be followed if sedation is needed during the biopsy.

EQUIPMENT: Patient monitor.

PRECAUTIONS:

1. Potential for pneumothorax with a lung biopsy.
2. Potential for bleeding with a liver biopsy, although risk is lower with use of CT imaging.

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3. Patient may have diet as ordered.
4. Observe patient for signs/symptoms pneumothorax (shortness of breath, tachypnea, pain, low SPO_2) or bleeding (hypotension, tachycardia, weakness, dizziness).
5. Patients may be up to the bathroom if stable after the 1st hour of observation (unless otherwise ordered by the Radiologist).
6. Patients may be discharged per the radiologist's order.

OBSERVATION FOLLOWING A MYELOGRAM:

To establish observation guidelines for patients who have had a myelogram in radiology. These patients do not usually require procedural sedation.

EQUIPMENT: Equipment to monitor vital signs and fluids for the patient to drink (after the procedure) should be available.

PRECAUTIONS:

- Headache, agitation, change in mental acuity, and seizure activity should be reported to the radiologist immediately.
- The patient should have head up upon arrival to the OPD, and throughout observation as ordered by the radiologist.
- The patient should start drinking fluids on arrival through the observation and after discharge (at home). This helps to dilute the contrast medium and decrease the likelihood of seizure activity.

Post-Procedure:

1. After the myelogram the patient will be brought to the Outpatient Unit via stretcher by a Radiology Technician. The Outpatient nurse should position the patient with the head of bed or gurney up 45 degrees or as ordered by the radiologist.
2. The patient should start drinking fluids. Check with the patient for preferences. A lunch may be ordered for the patient if okay with the Radiologist.
3. Vital signs should be taken on arrival and every hour unless needed more frequently.
4. Observe patient for CNS changes (headache, agitation, change in mental acuity, and seizure activity).
5. Patient can get up to the bathroom after one hour.
6. The Radiologist should be called if the patient needs an analgesic (or any other medication).
7. Patient can be discharged per the radiologist's order.

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MONITORING THE PATIENT IN THE MRI UNIT:

All patients that receive IV sedation will be monitored in accordance with the "Procedural Sedation" policy; this policy establishes frequency and type of patient information that must be monitored and documented. In addition the Radiologist or attending physician may ask that a patient be monitored during an MRI due to patient condition.

SPECIALTY EQUIPMENT:

1. MRI compatible monitor (kept in MRI unit)
2. Abrasive prep gel and 4x4 gauze, razor if necessary
3. Quadtrode EKG lead
4. Cannula (divided between prongs for monitoring end tidal CO2 and administering O2 if needed). The monitor ascertains a respiratory rate from the end tidal CO2; this is the only means of obtaining a respiratory rate on this monitor.
5. Medication as ordered for sedation and /or analgesia, syringes, alcohol swabs
6. Oxygen is in the MRI unit -- check tank for level
7. Ambu bag is kept in the MRI unit – check before starting procedure
8. Crash Cart (CT room)

PROCEDURE:

1. Check physician orders for sedation / analgesia.
2. Gather supplies and medications. Check with MRI Tech to ensure oxygen tank and patient monitor as well as any other equipment / supplies needed in the actual room with the magnet are MRI compatible (non-ferrous)
3. Check all emergency supplies before starting procedure (as mentioned above): oxygen, ambu bag, reversal agents etc..
4. Alert nursing supervisor that a scan with sedation will be started. The Radiology crash cart (located in the CT hallway) must be available.
5. Explain the procedure to the patient. Make sure the patient has signed consent for the sedation and a questionnaire for the MRI.
6. Make sure that all NPO instructions have been followed for any elective sedation procedure (see the "Procedural Sedation" policy).
7. If the patient is an outpatient make sure the patient has a responsible adult available to drive the patient home; the patient should know that he/she is not to drive for 24 hours after sedation.
8. Check that all old EKG leads and any other metal object has been removed from the patient; there is a place in the control room for patient valuables.
9. Establish IV access if needed. (This can be done before the patient enters the magnet room.)
10. Prep skin and apply EKG lead:
    - Shave area above heart if needed - about 4 inches high and wide
    - Apply skin prep gel and rub into skin briskly

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- Wipe off excess with a gauze pad

11. Apply Quadtrode EKG electrode pad as shown on package.
12. Connect electrode impedence monitor with the standard 3 leads (white- right arm, red- left leg and black- left arm). Check level of impedence. A green light means a safe level; anything 6K or less is a safe level. If not check that the EKG electrode pad is firmly adhered to the skin. A pad that has dried out will not have sufficient gel to reduce impedence; reprep skin and attach new electrode checking that the gel pad is still moist. Recheck with the impedence monitor.
13. Make sure that EKG cable extends down through the patients' legs and that there are no loops in the cable. For a scan in which the patient will enter the bore of the magnet feet first, put the leads on upside down and have the cable extend over the shoulder. Make sure that the patient is protected from cable heat by a layer of material under the cable.
14. Apply appropriately sized NIBP cuff.
15. Apply nasal cannula; this is necessary to obtain a respiratory rate as the respiratory rate is not obtained off of the EKG leads as it is on other monitors.
16. Apply SPO2 probe.
17. Apply oxygen if needed from the non-ferrous O2 cylinder in the magnet room.
18. Ensure the patient's comfort and establish mechanism for the patient to signal if he/she needs anything during the scanning. There is a microphone into the magnet room so the radiology tech., nurse, or doctor can communicate with the patient.
19. Set up parameters on the display monitor at the control room desk. Select a pre-programmed "monitoring package" or select individual options with the touch pads and dial.
20. Follow the "Procedural Sedation" policy for monitoring guidelines.

ANXIOLYSIS IN THE MRI UNIT:

Minimal Sedation (anxiolysis) in the MRI in order that the patient can tolerate being in the MRI machine. Adult patients may receive Versed 0.5mg IV over one minute, repeated every 2 minutes as needed for relaxation to a MAXIMUM dose of 4mg as ordered by the Radiologist.

If a patient needs pain medication in order to complete the testing, the Radiologist may order pain medication addition to the anxiolytic after assessing the patient. The pain will be assessed / documented using a valid pain scale and treatment of the pain will be addressed thoroughly as an issue separate from the need for anxiolysis.

PROCEDURE:

IV Access: saline lock or running IV will be started prior to the patient entering the MRI unit.

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Equipment / Supplies

- Equipment available which includes: crash cart with defibrillator, oxygen, suction, bag-valve mask, cardiac monitor, pulse oximetry, B/P monitor.
- Medication: Versed as ordered and saline for flushing IV.
- Reversal agents, romazicon (Flumazenil) and naloxone (Narcan) should be available.
- Monitoring: Use the MRI compatible monitor (kept in the MRI unit).

During the MRI, the RN will monitor the patient for:

- SpO2
- Respiratory rate
- Heart rate
- Blood Pressure
- EKG if patient has a significant cardiac history or at the discretion of the radiologist or monitoring RN

The Radiologist will be notified if the patient has:

- Respiratory rate <10
- SpO2 <90%
- Heart rate or blood pressure change of 20% from baseline heart rate or blood pressure

Discharge:
The patient may be discharged home 45 minutes after the last Versed dose was administered, as long as the discharge criteria from the Procedural Sedation policy has been met, and the patient has a responsible adult to drive him/her home.

VCUG: ASSISTING WITH A VOIDING CYSTOURETHROGRAM

The nurse inserts the catheter for this procedure. If sedation is required follow Procedural Sedation policy.

EQUIPMENT:

1. VCUG tray: Obtain from the outpatient department. Ensure the normal saline is not outdated and that the proper size catheter is in the tray (you may need to use a small feeding tube depending on the size of the child).
2. Prep solution (iodine povidine or Techni-Care)

PRECAUTIONS:

1. Chlorhexidine has not been approved for mucous membrane prep. Use an iodine povidine (Betadine) solution; if there is an allergy use a Techni-Care solution.

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2. Consider explaining procedure to parents before entering the radiology room so the parent can be supportive once the procedure has started. Also consider the use of a doll for teaching a child that is between the ages of 3 - 7, and / or distracting child with a toy – a donated stuffed animal from the ER supply might be used.

PROCEDURE:

1. Gather equipment (see above) and take it to Radiology when called that the patient is ready to be catheterized.
2. Explain procedure to patient (parent if applicable). Obtain written consent from patient or parent and check for patient allergies.
3. Wash perineal area per catheterization policy and catheterize patient using aseptic technique, if patient >1yr of age: fill balloon on catheter for patients < 1 yr. of age – consider taping catheter to hold in place instead of inflating balloon.
4. Connect catheter to contrast fluid tubing and infuse contrast material.
5. Stop infusion when patient begins to wiggle their feet and legs which indicates bladder is full enough. X-ray technician will obtain x-ray to confirm a full bladder and take X-Rays while the patient empties his/her bladder.
6. Deflate catheter balloon with a syringe if applicable and remove catheter. The X-ray technician then resumes responsibility for patient.

REFERENCE:

1. Procedural Sedation policy

Approval	**Date**
CCOC	7/17/17
Radiology	10/20/17
MEC	11/7/17
Board of Directors	11/15/17
Last Board of Directors Review	3/18/2020

Developed: 7/17
Revised:
Supersedes: Observation Following a Myelogram, Observation of the Lung or Liver Biopsy Outpatient, Monitoring the Patient in the MRI Unit, Anxiolysis in the MRI Unit, VCUG: Assisting with a Voiding Cystourethrogram
Index Listings: Nursing Care of the Outpatient Interventional Radiology Patient, Radiofrequency Ablation, Vertebroplasty, Observation of the Lung or Liver Biopsy, Observation Following a Myelogram, Monitoring the Patient in the MRI Unit, Anxiolysis in the MRI Unit, VCUG: Assisting with a Voiding Cystourethrogram

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Nutritional IV**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical**
Source: Director of Pharmacy	Effective Date:

POLICY:

An ER physician order for "Nutritional IV" will contain the following:

Dextrose 5% / 0.45% Sodium Chloride	1000 ml
Multi-Vitamins	10ml
Thiamine	100mg
Magnesium Sulfate	2Gm

Deviations from this standard mix require specific orders.

Once a patient is admitted to a patient care floor (Med-Surg, ICU, OB), additional IVs require specific IV orders, stating the solution and all individual additives and the appropriate amounts to be added.

The "Nutritional IV" order is approved for use by the ER physicians for IVs hung in the ER only.

Committee Approval Needed: Yes, P & T (9/17/98)
Responsibility for Review and Maintenance: Director of Pharmacy
Index Listings for Nursing Manuals: Nutritional IV; Alcoholic IV
_X_ Pharmacy Department Policy/Procedure
_X_ Medication Policy/Procedure
Revised: 9/98
Reviewed: 01/30/01 AW, 10-07bss
Last Board of Directors Review: 6/19/19, 3/18/2020

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NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope:	**Department:** Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director	**Effective Date:**

PURPOSE:

To ensure that the automated dispensing unit is utilized for the safe storage, handling, security, disposition and return to storage of medications

POLICY:

1. Pharmacy, Nursing Services, and other designated departments will utilize the OmniCell Automated Dispensing Unit (ADU) to store dispense, charge and account for controlled substance and non-controlled substance medications used in patient care areas where an OmniCell ADU has been installed.
2. In accordance with established policies and procedures for medication use, all record keeping requirements and dispensing practices will conform to federal and state laws and regulations.
3. The Director of Pharmacy shall be responsible for determining what classes of medications may be stored in the ADUs and may exclude individual medications or whole classes of medications from storage and availability in the ADUs.
4. Medications that may not be stored in the ADU include, but are not limited to:
    a. Cancer Chemotherapeutic agents
    b. Concentrated Electrolytes
    c. Sample Medications
5. All medications, solutions, and components used in preparation of medications stored in the ADUs will be labeled with the contents, expiration date, lot numbers, and applicable warnings.
6. Expiration dates of each medication, solution and component used in preparation of medications stored in the ADU's shall have their expiration dates recorded in the computer control of the ADUs. Items stored in the ADU's will be removed before their expiration dates by the pharmacy.
7. The contents of each ADU will be inspected monthly for expiring medications, damaged, or contaminated medications which shall be removed and quarantined in the pharmacy.
8. Access to the ADUs will be controlled by the Director of Pharmacy or designee via identification number and secure password.
9. Access to the ADUs and to specific storage portions of ADUs will be limited to licensed personnel by role-based access rules controlled by the Director of Pharmacy or designee, e.g., respiratory therapists will not have access to controlled substances.

Procedures

1. User Access

New Employees

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope:	**Department:** Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director	**Effective Date:**

1. New employees must complete the following prior to independent use of the automated dispensing system:

    a. Education from a Super User
    b. Competency assessed and documented.

ID Codes and Passwords

1. The employee's sign-on identification will be the employee's payroll number. The employee's identification number and secure personal password will serve as the employee's confidential electronic signature in the ADU. It is the employee's responsibility to protect their access codes and divulging, sharing, or any other inappropriate use of the employee's electronic signature is prohibited. Transaction records will be used for trending data and will be available to regulatory agencies.
2. Should any user believe that another person has knowledge of their ID and password, it is their responsibility to report this to their department manager and immediately change their password on the ADU.
3. The Director of Pharmacy or designee shall be the Pharmacy System Administrator and shall maintain a record of user sign-on identification numbers, which shall be available in the system software and stored securely. This record shall be available for inspection to authorized persons, such as Drug Enforcement Administration and the California State Board of Pharmacy.
4. The Pharmacy System Administrator will enter users into the ADU system and assign levels of security including but not limited to:
    a. Access to drug classes
    b. Access to individual ADU's
    c. Override ability
    d. Witness ability

Permanent Staff

1. For assignment of access for permanent staff, a request will be submitted to Human Resources and Information Technology. These will be routed to the Pharmacy System Administrator for processing.
2. The user will be prompted to enter a password when the user logs onto the system for the first time. Only the user knows the password. The password shall comply with the hospital password policy.
3. The Pharmacy System Administrator shall enter new users who are current employees only upon the request of a unit or department director or manager.
4. On weekends or holidays, or in the case of emergencies, the Nursing Supervisor or Unit Manager may provide access by assigning a temporary user code.

Temporary Staff

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope:	**Department:** Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director	**Effective Date:**

1. Unit Managers and Nursing Supervisors may assign a temporary access code to temporary staff or "float" for a period of 24 hours. This password will be created at the ADU using "Add Temp Nurse" procedure. All temporary access codes established in this manner shall expire in 24 hours.

Deletion of Codes

2. Whenever a user is terminated, Human Resources will notify the Pharmacy System Administrator via email. The Pharmacy System Administrator shall delete the user immediately.

Verification of Users

3. At least twice a year, in January and June, the user list will be generated by the System Administrator and will be updated by Human Resources. The Pharmacy System Administrator will correct any discrepancies in the system. This shall act as a failsafe for deletion of users.

Medication Removals, Returns and Wastes

Medication Removal and Administration

1. Personnel accessing the ADU shall select the patient and the appropriate medications and quantities to be removed.
2. Check the expiration date of all medications removed from the automated dispensing machine.
3. Upon completion of the transaction, the person shall document medication administration in the patient's record through the approved mechanism (MAR, anesthesia record, etc).

Controlled Substance Waste

1. When controlled substances are unusable, the dose should be discarded in the stericycle drug disposal bin and the "WASTE" function should be used to document the waste.
2. Two licensed personnel shall document wasted controlled substances, the person who wastes the medication and a witness. The witness must physically witness all wastes

Controlled Substance Medication Return

1. If a User removes a medication but does not administer it to the patient, it must be returned to the dispensing unit to avoid charging the patient for medications not administered. The "Return Med" function is used both to return the medication and to credit the patient.
2. After accessing the above function, the medication is returned to the "Return Bin", never to the drawers in the ADU.
3. For controlled substances, a witness is required to return medications that are reusable. The witness must physically observe the medication's placement in the "Return Bin".

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope:	**Department:** Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director	**Effective Date:**

4. The "Return Bin" will be emptied at each restock and a "Return Bin" receipt will be printed.
5. Medications in the bin shall be reconciled against the report by a pharmacist. Discrepancies will be investigated immediately.

Inventory Maintenance

Restocking Cabinets

1. Pharmacy will be responsible for the refill and loading of medications in each ADU. A complete list of medications stored in any unit may either be viewed on that unit screen or printed on that unit. The Pharmacy System Administrator may add or remove stocked items from the ADU.

Controlled Medications

2. Inventory levels will be checked via the pharmacy computer system, delivered and loaded into each ADU by pharmacy personnel. Routine refills of controlled substances by pharmacy personnel will not require a signature since all transactions are automatically recorded and saved in memory. Each time a unit is refilled, an inventory report will be generated to verify that medications dispensed have been loaded into the ADU. The first withdrawal of a dose serves to confirm the delivered inventory.
3. Pharmacy will generate a hard copy of the Transaction by Date report on a daily basis to serve as a permanent record of controlled substances transactions, as well as electronically archiving all data generated in the system on a daily basis. Such reports will be kept for 3 years.
4. When a controlled substance not previously stocked on that ADU is needed, pharmacy personnel must load it onto that location before being accessible to the nursing unit.

Non-Controlled Medications

5. Inventory levels will be checked via the pharmacy computer system, delivered and loaded into each ADU by pharmacy personnel to maintain par levels daily.
6. A Pharmacist will verify the accuracy of medications and quantity stocked by checking the fill list with the drug to be loaded.
7. At time of refill, pharmacy personnel will perform an actual inventory of those items being refilled, comparing actual physical inventory with the report. If discrepancies are discovered, a "Discrepancy Report" shall be generated.

Reports and Discrepancies

1. The pharmacy department will maintain records of all legend medications administered to a patient from the ADU. These records will be maintained for a minimum of 3 years.

Daily Batch Reports

2. The Restocking Technician will run the Transaction by Item by Par level report. This report is used to determine the need for medication replacement on each dispensing unit. The report can be discarded after the refill procedures. Stocking reports will be generated automatically by the system each morning. A critical item report will be generated automatically near the end of each day to ensure an adequate inventory during each night.
3. When emptying an ADU return bin, the Restocking Technician will generate a Waste and Return Drawer Reconciliation Report. The quantities returned from the bin will be verified against the quantities on the report and will be signed by a pharmacist.
4. The Restocking Technician will run the Transaction by patient report. This report shall be separated by medication class for Unscheduled medications, Schedule II medications, and those in schedules III-V. It will be reconciled with the MAR or other report of administrations each day providing 100% reconciliation of controlled substances..

Daily Discrepancy Reports

5. If a discrepancy in inventory is discovered during restocking of the ADU or during reconciliation of the return bin, a discrepancy report shall be generated at the unit and the department manager or designee will be notified.
6. Assigned pharmacy personnel will print and review all discrepancy reports for all locations, verifying that all discrepancies have been resolved.
7. The Director of Pharmacy (or designee in the absence of the Director) will be notified of unresolved discrepancies. The Director of Pharmacy shall report unexplained losses in accordance with applicable law.
8. Discrepancy reports shall be filed and retained for 3 years.

Monthly Procedures:

9. Pharmacy personnel will perform an inventory of medications in the ADU monthly and remove all medications that will expire in less than 30 days. The soon to expired medications will be returned to the Pharmacy and placed in the area designated for expired medications. Restocking of expired medications will occur at the next filling sequence.

Problem Solving

1. Each user shall be competent in loading paper into the ADU. Refer to the OmniCell Color Touch Quick Reference Guide or the OmniCell Pharmacy System User Guide.
2. Cleanliness is essential to proper functioning of the Omni Cell units. No food or drinks are allowed in the vicinity of the unit, nor should they be placed on top of any unit. Liquid spills and plastic tabs from drug packaging should be cleaned up and removed immediately, as they are a primary source of "drawer jams".
3. The user will refer to the "Quick Reference" guide to resolve malfunction problems.

4. The user will next contact the pharmacy.
5. Only the pharmacy will call the Omni Cell Help Line for assistance. The number is affixed to each unit. The number is 1 (800) 910-2220.
6. When a problem restricts the ability to access and document medication use appropriately, down time procedures shall be used until the unit is functional.

Down Time

1. The normal downtime procedure for inoperable ADU's is for the pharmacy to dispense any needed medication from the pharmacy.
2. If the inventory is only accessible from an ADU, and the ADU is inoperable (all problem resolution strategies have been tried), the manual lock override system can be used to unlock the unit.
3. The manual lock override can only be performed by a pharmacist, or pharmacy technician authorized by a pharmacist.
4. The pharmacist unlocking the unit is responsible for putting the Manual sign out log on the unit so that items removed can be documented manually.
5. Upon restoration of the system, the person responsible for unlocking the unit is assigned responsibility for relocking it and conducting a witnessed inventory of all controlled substances, as well as sending the manual sign out log to pharmacy so that items can be recorded and charged.
6. Upon arrival onsite to repair an ADU, and Omnicell representative shall report to the Pharmacy Department to obtain keys to the Omni Cell unit and to obtain information regarding the nature of the malfunction.
7. If the representative opens the unit a pharmacy technician or pharmacist will be present at all times.
8. If the unit is inoperable for an extended period of time, the pharmacists shall issue controlled substances in accordance with the controlled substance policy and procedures for units without ADUs.
9. In the event of a power loss to the ADU, each unit will automatically re-boot once power is restored. The unit will return to its last working state without user intervention.
10. Information stored on each dispensing unit is also stored in the central unit in the pharmacy. In the event that information on an ADU is lost, the central unit can re-transmit the necessary files back to the individual ADU. Each unit operates independently. If one ADU is down, it does not affect the operation of other units.
11. If the Omni Center (central unit) is not operating, each unit has the ability to continue functioning independently without communication with the central unit. Once the Omni Center is back on line and communication between the Omni Center and the units is restored, all units automatically reconnect to the center and have their transactions updated.

Disasters

1. Since all components of this system are connected to the emergency power supply, function of the system shall be maintained during an external disaster. In the event that power to the system is

Title: OmniCell Automated Dispensing Unit (ADU)	
Scope:	**Department:** Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, Nursing Administration, PACU, Perinatal, Pharmacy
Source: Pharmacy Director	**Effective Date:**

interrupted during the disaster, downtime procedures shall be initiated to perform and document transactions.

Committee Approval	**Date**
Pharmacy and Therapeutics Committee	
Medical Executive Committee	
Board of Directors	
Last Board of Directors Review	3/18/2020

Revised 4-7-15
Reviewed 10/06,10/09,10/11, 10/13

Responsibility for Review: Pharmacy / Compliance
Index Listings: OmniCell; Automated Dispensing Unit (ADU); Medication-OmniCell

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Oxygen Therapy**	
Scope:	Department: **Emergency Dept**
Source: Respiratory Therapy Director	Effective Date:

POLICY:

Oxygen (O2) therapy will be administered by a licensed RCP, nurse, or physician via nasal cannula, nasal mask, simple mask, non-rebreather mask, or any other mode deemed necessary to improve patient's blood oxygen level.

INDICATIONS:

1. Improve level of oxygen in the blood (O2 content)
2. To decrease myocardial workload
3. To maintain adequate oxygenation during times of mild hypoventilation, such as post-op patients and those who have procedures done under conscious sedation.
4. For comfort measures
5. Trauma victims

PROCEDURE:

1. Obtain physician order. However, do not delay oxygen administration when clearly indicated. i.e. low SpO2 - Give oxygen first, then contact physician for order.
2. Gather appropriate equipment: flow meter or cylinder, O2 deliver device, humidifier where applicable (>3L/m)
3. Explain procedure to patient. Obtain interpreter for non_English speaking or hearing impaired patient to ensure they understand the need for oxygen and safe use. Where there is any doubt, make sure patient is aware that NIH is an non-smoking hospital (foreign countries may have different policies).
4. Connect O2 delivery device to either wall outlet flow meter or cylinder flow meter and check proper function by feeling or listening for flow. When using cylinder, check regulator pressure.
5. Place delivery device on patient and monitor SpO2 until desired level is reached. Flow adjustments may be necessary. Assess patient for adverse effects.
6. Document procedure and complete care plan. Notify patient's nurse of current flow settings.

POLICY STATEMENTS:

1. The Respiratory Care Practitioner will initiate and discontinue oxygen therapy. Oxygen therapy may be also be administered by nurse who will then notify RCP
2. Physician order may be written as: O2 @ specified liter flow and should include delivery device (nasal cannula), or it may be written to achieve a specific SPO2. i.e. O2 to keep SpO2 > 92%. When O2 is ordered in this way, it is up to the RCP to adjust liter flow and/ or delivery device to maintain desired SpO2 level. Notify physician of what level patient is currently on.
3. When post op patients are brought to ICU or A-Floor on O2, verify need for oxygen by obtaining and documenting room air SpO2.

Title: **Oxygen Therapy**	
Scope:	Department: **Emergency Dept**
Source: Respiratory Therapy Director	Effective Date:

SPECIAL CONSIDERATIONS:

1. Sometimes a patient will be ordered for "O2 for Comfort". This is written for patients that have DNR orders and are usually near death. It is important that the RCP communicate with both the patient's doctor and nurse as to what is going to be a proper liter flow for the patient's "comfort". SpO2 checks are not documented unless ordered.
2. When a patient is suspected to be a CO2 retainer, or is documented as such, use caution in administering oxygen therapy. Especially when increasing liter flow.
3. See separate policies regarding oxygen delivery devices and oxygen delivery to infants/pediatric patients.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Pap Smear Specimen Handling and Collections**	
Scope: Single department	Department: **Emergency Dept, Rural Health Clinic**
Source: RHC Nurse Manager	Effective Date: 10/28/2009

PURPOSE:

To assist the provider as needed during the specimen collection, labeling specimen and completion of laboratory requisitions.

PROCEDURE:

The PAP smear collection is performed by the provider during the clinical pelvic exam. The sample can be collected and placed into a liquid prep solution or onto a glass slide. The determination of the type of prep for the PAP smear is decided by the provider and is often based on the patient's clinical condition and requirement of their insurance type.

Collection of the PAP smear placed on a glass slide

Equipment required:
Vaginal Speculum
PAP kit with slide, spatula, brush, and slide holder
Cytofix
Non-sterile gloves
Water-soluble lubricant

1. Label the frosted end of the glass slide in Pencil
    a. patient's name
    b. date of collection
    c. source of sample
2. Complete PAP smear lab slip by the provider
3. Application of sample on slide by the provider followed by immediate spray of Cytofix
4. Close cardboard container and place in biohazard bag with lab requisition and copy of patient's insurance cards. Place into Lab Corp pick-up box.

Collection of the PAP smear in Liquid Based Solution

Equipment required:
Vaginal Speculum
Liquid PAP bottle
Cervical Broom
Large Cotton Swab x 2
Cervical Brush
Non-sterile gloves
Water-soluble lubricant

1. Label the Liquid Based PAP bottle
    a. patient's name
    a. date of collection
    b. source of sample

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Pap Smear Specimen Handling and Collections**	
Scope: Single department	Department: **Emergency Dept, Rural Health Clinic**
Source: RHC Nurse Manager	Effective Date: 10/28/2009

2. Complete PAP smear lab slip by the provider
3. Cervix is cleansed with large cotton swab by provider
4. Cervical Broom is inserted into cervical-os by provider and rotated 5 times
5. Broom is swirled in the liquid prep solution then removed from its handle and placed into the liquid prep container.
5. Provider may collect endo-cervical sample by brush. The brush is swirled in the liquid PAP solution, but not left in the solution.
6. Place Liquid Based PAP bottle into biohazard bag with lab requisition and copy of patient's insurance cards. Place into Lab Corp pick-up box.

SPECIAL CONSIDERATIONS: The Pelvic exam may require collection of other samples in addition to the PAP smear.

Provider order required **X Yes** **_____ No**
Procedure may be performed by: **X RN X LVN X Clinic TECH _____CLERK**
Special education required to perform procedure: **_____Yes X No**
Age specific considerations: **no**

Index Listing: Pap Smear

Committee Approval	**Date**
Not required	
Last Board of Directors Review	6/19/19

Revised 10/28/2009
Reviewed 4/14bss

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **PAPR Respirator Inspection Record**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Respiratory**
Source: Respiratory Therapy Director	Effective Date:

Serial Number

Head Cover
Check that there are no tears or punctures in the hood assembly. Look closely at the stitching. There should be no tears that could permit contaminated air to enter the head cover.

Visor
Look for scratches or other visual distortions that make it difficult to see through visor.

Breathing Hose
Carefully examine the entire breathing hose. Look for tears, holes or cracks. Bend the hose to verify that it is flexible.

PAPR Blower Unit
- Remove that cartridges and assure that the rubber gaskets are in place.
- Examine the blower housing for cracks. Replace if cracked or damaged.
- Examine the outside of the battery pack for cracks. Replace if damaged

Cartridges
Examine cartridges for mechanical damage and deformities. Replace if damaged.

Blower Plug
Examine the plug in the blower inlet, and insure a tight seal against the internal gasket. Re-tighten if necessary.

	No Defects	Defects Found*
*Add Comment if defect is found		
Head Cover		
Visor		
Breathing Hose		
Blower Unit		
Cartridges		
Blower Plug		

Month	Please Date and Initial	Month	Please Date and Initial
January		July	
February		August	
March		September	
April		October	
May		November	

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **PAPR Respirator Inspection Record**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Respiratory**
Source: Respiratory Therapy Director	Effective Date:

June		December	

If defects are found, make comment on what was defective, label with "Defective Sticker, remove PAPR from service, and notify department manager and Bio-Med.

Committee Approval	**Date**
Administration	
Board of Directors	
Last Board of Directors Review	3/18/2020

Responsibility for review and maintenance:
Index Listings:
Developed:
Revised:
Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Patient Valuables and Personal Effects in the Emergency Room**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date: 1/95

POLICY:
The hospital does not assume responsibility for valuables voluntarily kept by the patient, nor for the loss or damage of personal belongings of patients not deposited in a hospital safety deposit box. Personal effects will be inventoried and labeled. When the hospital Admitting Department is closed, the Emergency Room Clerk will lock the valuables in the safe.

PURPOSE:
To protect the patient from loss and the hospital from liability.

SPECIAL CONSIDERATIONS:
Physician order is not required.
Procedure may be performed by: X RN, X LVN, X ER Tech
Special education required to perform procedure: NO
Age specific consideration: NA

PROCEDURE:
1. For the alert, conscious, non-critical patient, personal belongings are placed in a labeled bag or envelope and kept with the patient, and are the patient's responsibility. If the patient is sent to X-ray, property is kept with the patient on the guerney, wheelchair or hand carried, or given to patient's family, significant other, or friend upon patient's request and documented.
2. If the patient is unconscious or incoherent, valuables should be bagged, labeled and locked in the hospital safe and so noted on patient's chart. Double signatures are required if valuables are given to family. The family must sign for and note name of person with itemized list of belongings given to them.
3. If the patient is transferred, all effects are placed in a labeled bag and either -
    a. given to the patient, who must sign for any valuables.
    b. given to ambulance attendants, who must sign for them
    c. given to the family, who must sign for them
4. If the patient is DOA or expires, the valuables are given to the family, except in a coroner's case, following signature.
5. In a coroner's case, the personal effects are labeled and given to the coroner. He will then give permission for valuables to be released. The coroner will sign for valuables.
6. Signatures are required by both ambulance attendant and nurse when receiving valuables from an incoming ambulance transfer if the patients is unconscious or incoherent.

DOCUMENTATION:
The disposition of valuables and personal effects will be charted on the Emergency Room record.

Committee approval needed: x No
Responsibility for review and maintenance: E.R. Head Nurse
Index Listings: Valuables in the E.R.; Patient Valuables in E.R.
Revised: 1/95; 2/2001
Reviewed: 6/11as; 2/15as
Last Board of Director review: 7/18/18; 6/19/19

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Patient Warmer (Warm Air Hyperthermia System)	
Scope:	Manual: Anesthesia, Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Surgery
Source: Surgery Nurse Manager	Effective Date:

SURGICAL UNIT / POST ANESTHESIA CARE UNIT

PURPOSE:
The Patient Warmer (Warm Air Hyperthermia system) or Bair Paws patient gown provide a continuous flow of heated air to the peripheral areas of the patient.

It is used to treat/prevent intraoperative/postoperative hypothermia and the discomfort associated with it.

POLICY:
In the Operating Room the anesthesiologist will monitor patient temperature either by core or surface monitoring for all anesthetics equal to or greater than 30 min. duration.
A temperature will be taken on each patient on admission to the PACU. The anesthesiologist will be notified of a temperature < 35.5 degrees C (96 degrees F). The warmer will be applied as ordered by the anesthesiologist. The warmer will stay in place until the patient's temperature reaches 35.5 degrees C and the patient feels comfortable or as ordered by the anesthesiologist.

ALL OTHER UNITS:

PURPOSE:
To treat hypothermia and the discomfort associated with it, maintain and regulate body temperature.

POLICY:
The warmer, or Bair Paws gown applied pre-operatively, will be applied and will stay in place until the patient's temperature reaches 35.5 degrees C. or as ordered by the physician.
Temperature will be taken every 15 minutes until desired temperature has been reached.

SPECIAL CONSIDERATIONS:

Physician Order Required: ____No _X_Yes
Procedure may be performed by _X_RN, _X_LVN, _X_OR Tech
Special education required to perform procedure:_X_No, ___Yes
Age specific considerations: Pediatric ages/infants require size/age specific warming blankets

EQUIPMENT:

Warm Air Hyperthermia System (Bair Hugger Model 500/505)
Bair Hugger Model 775
Bair Paws patient warming gown and warming unit.
Warming tube / Blanket of choice: Sheet or Cotton blanket

PRECAUTIONS:

1. The Bair paws gowns/tubes/Blankets are not sterile.
2. The Bair paws gowns/tubes/Blankets are designed for single patient use.
3. Turning the on/off switch will not provide airflow.

Title: Patient Warmer (Warm Air Hyperthermia System)	
Scope:	Manual: Anesthesia, Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Surgery
Source: Surgery Nurse Manager	Effective Date:

4. Monitor the temperature and cutaneous response of patients who are incapable of reacting, communicating and/ or who are without a sense of feeling every 10 -20 minutes. Monitor the patient's vital signs regularly. Adjust air temperature or discontinue therapy when the therapeutic goal is reached or if vital sign instability occurs. Notify physician of vital sign instability immediately.
5. Do not leave pediatric patients unattended during therapy.
6. Do not initiate temperature management therapy unless the temperature management unit is safely placed on a hard surface or securely mounted. Otherwise injury may result.
7. The Model 775 in use in the OR is mounted on an encasement with a rolling caster base and is not mounted on an IV pole. If mounted on an IV pole, to prevent tipping, clamp the Model 775 temperature management unit to an IV pole with a minimum wheelbase of 28" (71 cm) no higher than 44" (112 cm) to provide stability.
8. Electrical shock hazard. Do not disassemble the Model 775temperature management unit unless you are a qualified service technician. There are electrically live parts within the unit when it is connected to a power source, even when the unit is in *Standby* mode.

BAIR PAWS UNIT MODEL 875

Depressing the ambient temperature switch will provide airflow of room temperature only.

Indications/Intended Use

The Model 875 warming unit is indicated for patient warming. This warming unit has been designed for use with the Bair Paws warming gowns in all preoperative and postoperative settings.

BAIR HUGGER MODEL 500/505:

The Model 500/505 warming unit is a forced air temperature management unit.
This unit can be used in all clinical settings including the operating room to provide patient temperature monitoring.

Contraindication:

Do not apply heat to lower extremities during aortic cross-clamping. Thermal injury may occur if heat is applied to ischemic limbs.

USE OF THE HIGH TEMPERATURE SETTING IS CONTRAINDICATED when treating patients who have:

Significant peripheral vascular disease (occlusive or diabetic)
Low cardiac output
Total immobilization

Warnings:

- Do not warm patients with the warming unit's hose alone. Thermal injury may result. Always connect the hose to a Bair Paws warming gown or **blanket (Model 500/505)** before providing patient warming.

Title: Patient Warmer (Warm Air Hyperthermia System)	
Scope:	Manual: Anesthesia, Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Surgery
Source: Surgery Nurse Manager	Effective Date:

- Do not use a forced-air warming device over transdermal medications; increased drug delivery, patient death, or injury may occur.
- Use only Bair Paws warming gowns with the **Model 875** warming unit. This warming unit has been designed to operate safely with Bair Paws warming gowns; use with other products may cause thermal injury. To the full extent permitted by law, the manufacturer and/or importer decline all responsibility for thermal injury resulting from the unit being used in conjunction with products other than Bair Paws warming.
- Use only Arizant Healthcare disposable components. Use with other products may cause thermal injury. **Model 500/505**
- Do not allow the patient to lie on the warming unit hose or allow the hose to directly contact the patient's skin during patient warming; thermal injury may result.
- Do not leave patients with poor perfusion unmonitored during prolonged warming therapy sessions. Thermal injury may result.
- **Do not** place the **non-perforated** side of the blanket on the patient. Thermal injury may result. Always place the perforated side (the side with small holes) towards the patient. **Model 500/505**
- Do not continue temperature therapy if the Over-Temp indicator light illuminates and the alarm sounds. Thermal injury may result. Unplug the unit, and contact biomed.
- Position the temperature controller cord and the hose away from the patient's neck or shoulders to avoid entanglement and/or injury. **Model 875**
- Equipment not suitable for use in the presence of a flammable anesthetic mixture with air or with oxygen or nitrous oxide.
- Reusable blankets made from woven fabric, or blankets without discrete, visible holes, can cause the safety system of this unit to fail, which may result in serious thermal injury. This warming unit has been designed to operate safely ONLY with the Bair Hugger blankets or Bair Paws gowns. **Model 500/505 / 750/ 775**
- **The Model 875 warming unit is not intended for use in the operating room.**

PROCEDURE:

1. If using a Bair Paws patient warming gown, have patient dress in gown as shown on package insert.
2. Attach hose from warming unit to inlet port on gown, and give patient control unit.
3. Turn on unit, and have patient use control knob to control heat to a level of comfort.
4. If using warming tube or blanket, remove the warming tube/blanket from the package.
5. Partially unfold the warming tube/blanket at the foot of the stretcher, air inlet port away from the patient's feet.
6. Insert heater hose into air port on the warming tube. Attach clip to the bottom of the sheet to anchor tube.
7. Plug warmer in, turn switch, select desired temperature (low temperature 90 degrees F/32.2 degrees C; medium temperature 100 degrees F/37.8 degrees C; high temperature 110 degrees F/43.3 degrees C). The warming tube will fully inflate and extend towards the patient's head. The ties may be used to secure the warming tube (tie across the patient, tie to the side rails or place under the patient).
8. Cover the patient with a single sheet or cotton blanket. Any covering too heavy will impede the flow of warm air. The patient must have a sheet or blanket on to hold the air around his/her body.
9. Monitor temperature with other PACU vital signs.

Title: Patient Warmer (Warm Air Hyperthermia System)	
Scope:	Manual: Anesthesia, Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Surgery
Source: Surgery Nurse Manager	Effective Date:

10. Discontinue when temperature of 96 degrees F is reached and the patient is comfortable or otherwise ordered by anesthesiologist.
11. Patients with **poor circulation should be started on a low or medium temperature setting** (not high). See the operation and technical manual with the machine for alarms (pages 19/20). The filter should be checked every month and changed as needed.

MODEL 775 TEMPERATURE MANAGEMENT UNITS

Description

The Bair Hugger brand Total Temperature Management consists of a system Model 775 forced-air temperature management unit and disposable components including Bair Hugger forced –air blankets, Bair Paws* patient warming gowns and the 241* blood/fluid warming set.

1. This unit is currently being used in the operating room only.
2. Airflow Modes
   It has two airflow settings:
   - a default High Fan Setting and a Low Fan Setting and hose-end temperature sensing for precise temperature delivery.
   - The unit will default to the high flow setting each time the unit is powered up or *Standby* is selected.
   - The low fan setting maybe pre-selected while in *Standby* prior to selecting the desired temperature.
3. It is compatible with all Bair Hugger blanket styles- pediatric to adult.
4. It tracts and reports therapy, duration, hours, used (via built-in meter), fault codes.

Temperature Modes

- Press the **32 deg C** (Low), or **38 deg C** (Med) or **43 deg C** (High) button to select the desired temperature.
- Press the *Ambient* button to supply room temperature air.

When you select a temperature mode, the following events occur:

- Corresponding temperature indicator and fan setting lights illuminate.
- Blower operates at selected speed.
- Fan setting indicator light illuminates.
- Temperature at the blanket or gown end of the hose appears in alphanumeric display.
- Heater activates except in *Ambient* mode.
- Temperature mode timer activates (or resets itself if changing from one temperature mode to another).

Standby:

Upon power up, the warming unit defaults to *Standby* and the high fan setting. When the unit is in 32 deg C (Low), 38 deg C (Med), or 43 deg C (High) or *Ambient* mode, press the *Standby* mode.

When you select the Standby mode, the following events occur:

- *Standby* indicator lights illuminates.
- Blower and heater are turned OFF.
- Alphanumeric display deactivates.

Title: Patient Warmer (Warm Air Hyperthermia System)	
Scope:	Manual: Anesthesia, Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Surgery
Source: Surgery Nurse Manager	Effective Date:

- Alarm and fault detection functions remain active.
- Operating timer pauses.
- Airflow mode resets/defaults to the high fan setting.

Temp In Range Indicator Light
The *Temp in Range* indicator light illuminates when the temperature at the blanket or gown end of the hose is + or – 1.5deg C of the selected setting; this indicator light does not illuminate in the ambient mode.

Fault Indicator Light
When a system fault occurs, the amber *Fault* indicator light flashes and an alarm sounds.
Note: Pressing any button will silence the alarm.

If a fault condition occurs:
1. Unplug the temperature management unit and wait for 5 minutes.
2. Reconnect the temperature management unit to a grounded power source.
3. The unit will perform the normal power-on-reset sequence and then enter the *Standby* mode.
4. Reselect the temperature setting.
5. If the unit does not return to normal operation, contact a qualified service technician.

Over-temp Indicator Light
If the unit senses an over-temperature condition, the red *Over-temp* indicator light flashes and an alarm sounds.

What to Do in case of an Over-Temperature Condition Occurs:
1. Discontinue all temperature management therapy. If you are using the 241 fluid blood/fluid warming system, immediately stop fluid flow and discard the blood/fluid warming set.
2. Unplug the temperature management unit.
3. Contact a qualified service technician.

General Maintenance for Model 775

CLEANING THE CABINET AND HOSE:

WARNING:
Do not immerse the cabinet or hose while cleaning. Moisture will damage the components, and thermal injury may result.

PRECAUTIONS:
- Do not use dripping wet cloth to clean the cabinet. Moisture may seep into the electrical contacts and damage the components.
- Do not use alcohol or other solvents to clean the cabinet. Solvents may damage the labels and other plastic parts.

Method:

Title: Patient Warmer (Warm Air Hyperthermia System)	
Scope:	Manual: Anesthesia, Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Surgery
Source: Surgery Nurse Manager	Effective Date:

1. Disconnect the temperature management unit from the power source before cleaning.
2. Wipe the cabinet and the outside of the hose with a damp, soft cloth and a mild detergent or antimicrobial spray.
3. Dry with a separate soft cloth.

DOCUMENTATION:

1. In the Operating Room, Anesthesiologist assumes responsibility for the warming unit and notes on his record – Nurse will note on intraoperative order sheet.
2. Time warmer applied, patient's response to the warmer (temperature etc.) and the time the warmer was discontinued in the nurses notes (PACU record).
3. Nursing units will document on patient record.

Committee Approval needed: ___ No, _X_ Yes Surgery Tissue/Anesthesia
Responsibility for Review and Maintenance: Surgery Nurse Manager
Index Listing: Warm Air Hyperthermia System/Warmer/Patient Warmer
Revised: 1/98 BS/AW; 05/2011BS, 10/11/11
Last Board of Director review: 1/17/18; 1/16/19; 6/19/19, 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Patients Under the Influence of Drugs Management of**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

POLICY:
Patients under the influence of drugs (other than alcohol) who present to the emergency department should be evaluated and treated, appropriate follow-up care should be arranged. Drug abuse patients requiring hospitalization should be treated medically in the emergency room initially. Any patient presenting to the emergency room after "ingestion" as a suicide attempt is treated appropriately. A police report is not made on these cases, according to the State Penal Code, unless report is about injuries or illnesses that may be the result of a criminal act unrelated to self-administered drug or alcohol. Law enforcement may be notified for possible 5150 hold after stabilization.

PROCEDURE:
1. The patient chart should be completed as usual.
2. The patient should be placed in an area of privacy.
3. Every effort should be made to determine what drugs have been taken, either from the patient or the person accompanying the patient. SAVE ALL BOTTLES BROUGHT IN WITH THE PATIENT.
4. Contact Poison Control as needed to determine appropriate treatment for type of ingestion.
5. If the patient is unconscious, careful, but thorough gastric lavage should be attempted. Airway should be protected.
6. If conscious, consider gastric emptying and/or charcoal administration. All stomach contents are labeled and saved for potential analysis.
   If the patient refuses treatment and is judged a danger to himself or others, call law enforcement for 5150 hold.
7. Restraints as determined by the physician. (Following current restraint protocol)
8. Contact Mental Health as soon as patient is no longer under the influence for evaluation and determination of need for 5150 hold.

DOCUMENTATION
Document assessment, procedure and interventions, outcome of interventions. Disposition of patient.

Committee Approval Needed: No
Responsibility for Review and Maintenance: ER Head Nurse
Index Listings: Drug Abuse Patient; Patient under Influence of Drugs; Reporting Requirements: Drug Influence
Reviewed/Revised: 1/2000; 11/02; 2/15as
Last Board of Director review: 7/18/18; 6/19/19

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Pediatric Order Verificaton Overnight	
Scope: Emergency Department	Manual: Emergency Dept, Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 6/15/18

PURPOSE:
The intent of this policy is to minimize risk of dose related medication errors occurring for pediatric orders.

POLICY:

1. During the overnight shift (17:01 - 06:29), emergency room staff will be required to call the on-call pharmacist to verify pediatric (patient is <= 18 years old or <=36 kg)(1) medication orders. Due to max dosing restrictions on select drugs, this policy is not meant to replace clinical judgment on a clinician's interpretation of a pediatric order. Pharmacists do not need to be called on the following oral medications:
    a. Ibuprofen
    b. Acetaminophen
    c. Diphenhydramine
    d. Amoxicillin
    e. Amoxicillin/Clavulanic acid
    f. Dexamethasone
    g. Prednisolone
    h. Ondansetron
    i. Azithromycin
    j. Cefdinir
    k. Cefixime
    l. Cephalexin
    m. Penicillin
    n. Sulfamethoxazole/Trimethoprim
    o. Albuterol nebulized solution*
2. All pediatric medications orders in the electronic health record will be built to have a mg/kg ordering format except for albuterol nebulized solution. If further medications are deemed to be clinically inappropriate to have a mg/kg ordering format, the appropriate committees will review the medications in question.
3. Only one concentration of a given liquid medication may be available in the Omnicell.

References:

1. Pediatric Definition. Accessed 3/27/18
2. Meeting with Northern Inyo Associate Pediatric Department 3/13/2018.
3. Paragon ordering system review Quarter 1, 2018.

CROSS REFERENCE P&P:

1. High alert medications policy and procedure.

Approval	Date
Emergency Room Service Committee	03/14/18
MEC	04/03/18

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Pediatric Order Verificaton Overnight	
Scope: Emergency Department	Manual: Emergency Dept, Pharmacy
Source: PHARMACY DIRECTOR	Effective Date: 6/15/18

Board of Directors	04/18/18
Board of Directors Last Review	6/19/19

Developed: 3/13/2018nv
Reviewed:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pentax Emergency Bedside Intubating Laryngoscope	
Scope:	Manual: Emergency Dept, Surgery
Source: Surgery Nurse Manager	Effective Date:

PURPOSE:
For the assistance of endotracheal intubation on difficult airway patients.

POLICY:
This procedure will be followed when any emergency intubation using laryngoscopy is performed.

PHYSICIAN ORDER REQUIRED: _X_Yes ___NO
PROCEDURE MAY BE PERFORMED BY: X_MD
Set up, cleaning and processing may be performed by: _X_RN _X_ TECH
SPECIAL EDUCATION REQUIRED TO PERFORM PROCEDURE: X_Yes ___NO
Must be inserviced to equipment and its function.

EQUIPMENT:
- Pentax Laryngocopy cart
- Pentax light source, light cable or battery adaptor
- Suction set-up

SPECIAL CONSIDERATIONS:

- This instrument is ***extremely delicate***.
- Care must be taken to make sure that the distal end is not damaged, especially by hitting against any hard surface, or by being pinched in a drawer.
- The suction channel is easily occluded by saliva/secretions and must be ***cleaned immediately*** after use, or at least irrigated without fail.
- The scope operated by the use of a lithium battery, which is in the adaptor, make the scope very portable to the bedside. It can also be used in the traditional manner by attaching the light cable to the scope and light source.
- For sterile surgical procedures, attach battery to scope, making sure it is OFF position-with battery attached it may be put in steris for processing prior to the procedure

PROCEDURE:
Assemble the following equipment:
1. Remove scope from drawer. Assure that **Battery Adaptor** is attached to scope, turn on light to verify proper function. (If desired, scope can be used with light source located on top of cart. Remove Battery Adaptor and attach light cable to scope and Pentax light source.
2. Attach suction tubing to scope.
3. Have available: procedure gloves, lubricant/spray of doctors choice (cart).
4. If time allows, fill emesis basin with water, aspirate fluid through scope to check proper function of the suction.
5. E.T. tube of physician's choice.
6. Bite block if patient has teeth or dentures

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Pentax Emergency Bedside Intubating Laryngoscope	
Scope:	Manual: Emergency Dept, Surgery
Source: Surgery Nurse Manager	Effective Date:

FOR STERILE OPERATING ROOM PROCEDURES:
Attach battery to scope making sure it is in the OFF POSITION – may be put in STERIS FOR STERILIZATION PRIOR TO PROCEDURE.

IMMEDIATELY AFTER PROCEDURE:

1. Mix Enzymatic solution per manufacturer instruction and aspirate solution through working channel.
2. Push syringe full of solution through scope (attach at suction connector) and let set for 3-5 minutes.
3. Remove black cap and clean with enzymatic solution.
4. Brush suction channel well and suction fluid again until returned fluid appears clear.
5. Clean outside of scope with enzymatic solution and a soft cloth.
6. Soak in glutaraldehyde OPA per policy for Cleaning and Sterilization or Chemical Disinfectant of Equipment.Rinse thoroughly at least three times and blow dry before returning to storage.
7. May also be processed in Steris per policy.

- Notify Respiratory Therapy or Surgery for terminal sterilization using the Steris machine in Central Supply.

References: Manufactures Literature On Pentax Scope.
Committee Approval Needed: ____Yes X No
Responsibility For Review And Maintenance: Surgery Nurse Manager
Index Listings: Pentax Intubating Bedside Laryngoscope; Laryngoscope, Emergency Bedside; Laryngoscope; Fiberoptic Rhinolaryngoscope, Rhinolaryngoscope Fiberoptic
Revised: 07/00bs; 3/2012 BS
Last Board of Director review: 7/18/18; 1/16/19; 6/19/19, 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Photo Documentation Policy**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

Policy

Photodocumentation of injuries is the accepted standard of care. Photodocumentation is an extremely important service that should be offered to the patient. Photographs require written informed consent and become part of the medical record.

Purpose

The purposes of Photodocumentation are as follows:

1. To record and communicate that which cannot be communicated with the written word alone.
2. To serve as objective witnesses by providing photographic evidence for purposes of adjudication.
3. To protect healthcare providers against claims of inappropriate care or failure to accurately document physical appearance, condition, or injuries.

Procedure

Follow proper procedures when considering photodocumentation.

1. Determine the need for photodocumentation. Forensic categories of patients potentially requiring photographs include, but are not limited to, the following:
    - Abuse of children, elders, disabled
    - Domestic violence
    - Negligence and malpractice
    - Transcultural medical practices (e.g., cupping, coining, tribal scarring)
    - Environmental and toxic hazards
    - Forensic psychiatric situations (e.g., suicide attempts, hesitation marks, burns, self-mutilation)
    - Transportation injuries (motor vehicle, motorcycle, boating, airplane, railroad))
    - Sexual Assault
    - Assault and battery
    - Personal injury
    - Occupation-related injuries
    - Questioned death
    - Product liability
    - Human and animal bites
    - Sharp force injuries (stabbing, puncture)
    - Burns over 5% body surface area
    - Firearm injuries
    - Gang violence
    - Acts of terrorism resulting in mass destruction of property or injuries of victims
    - Any other suspicious, unrecognized, or unidentified trauma
2. Informed consent must be obtained. Signature is required on the consent for photography or in the general consent for treatment, and signed by the patient, guardian, or caretaker upon arrival to the ED. In emergent cases when a signature is unobtainable, consent can be implied.
3. Steps in photodocumentation injuries
    - Take "before" and "after cleaning" photographs of all injuries. This is most important in recording blood spatter patterns, gunshot residue, and dirt.

Title: **Photo Documentation Policy**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

- Take a full-length photograph that captures both the patient's face and injuries so that it is clear that the trauma was sustained by the victim in the photograph. Also take a full-length photograph of the back of the patient with the head turned toward the camera. This objectively records both presence and absence of injuries. Respect a patient's privacy. Allow the patient to cover up with a blanket or sheet, moving it to expose only the areas and injuries that need to be photographed.
- If the location of the injury does not allow for such a photograph, the nurse will place a patient's label in the photograph as a patient identifier.
- Take a close up photo of each of the injuries. The face is not required in these photographs. Identification has already been established with the full-length and labeled photographs.

4. Label each photograph with the date and time taken, the date and time taken, the name of the hospital, the medical record number, and the initials of the photographer. Do not write on the back of the photograph. Place this information on a self-adhesive label and affix the label to the back of the photograph.
5. Photographs are to be kept in the patient's medical record in a sealed envelope with the written statement "photograph of patient's injuries.

Last Board of Director review: 7/18/18; 6/19/19

Physician Orders - Thrombolytic Therapy for Acute Ischemic Stroke – With Alteplase
Northern Inyo Hospital- Emergency Services

Date/Time: _____Diagnosis_____

Allergies: _____Ht: _____ Wt: _____ ☐ Actual ☐ Stated

☐ Baseline Vital Signs, including temperature (with prompt treatment of fever if necessary).
☐ Monitor: BP and Neuro checks every 15 mins. X 2 hours, then every 30 mins, if stable, until transfer.
☐ Continuous cardiac monitor.
☐ Administer Oxygen at 2L/min, or as needed to maintain SpO2 of 95% or greater. Monitor with pulse oximeter.

Diagnostics:

- ☐ Non-Contrast CT Head Scan Interpreted by Radiologist or Neurologist. (Goal: CT within 25 mins. of arrival and CT interpretation called to ED Physician within 45 mins.).
- ☐ Laboratory Studies on arrival: CBC with Differential; PT , PTT, and Fibrinogen; Chem 14; Type and screen. (Fingerstick blood sugar on arrival)
- ☐ Electrocardiogram. ☐ Other:_____

☐ Physician to complete the National Institute of Health Stroke Scale (NIHSS). **Score**: _____
☐ Mandatory neurology consult. Neurologist: _____ Contact Time: _____
☐ Obtain informed consent for treatment with thrombolytic therapy with Alteplase.
☐ Thrombolytic therapy must be started **within 180 minutes** from the onset of the stroke.
☐ No Heparin or Antiplatelet drugs for 24 hours.
☐ 3 IV lines: 18 gauge preferred. May have 2 IVs and 1 saline lock.

GUIDELINES FOR BLOOD PRESSURE CONTROL: **GOAL: SBP less than 180mmHg, DBP less than 105**.
If Systolic BP is greater than 230mmHg or Diastolic BP is greater than 140mmHg on 2 readings 5 minutes apart, start Nitroprusside (per Standard Mix Calculator and titrate to effect).
If Systolic BP is 180-230 mmHg, Diastolic BP 105-140mmHG, or MAP >130 mmHg on 2 readings 20 minutes apart, other antihypertensives to consider:

- Labetalol 10-20 mg slow IVP. May repeat every 10 min. with 20-40mg prn. Max dose: 150mg.
- Enalapril 1.25 mg slow IVP. May repeat 1.25-2.5 mg in 30 min. prn. Max dose: 20mg/24 hrs.
- Metroprolol 5mg slow IVP. May repeat every 10 min. prn. Max dose: 5pm
- Esmolol 500 mcg/kg IVP over 1 min, then infuse 50mcg/kg/min. Titrate q5 mins up to 200mcg/kg/min.
- Nicardipine 5mg/hr IV. May titrate by 2.5mg/hr q 5 minutes. Max dose: 15mg/hr. After reaching goal BP, turn the drip down to 3mg/hr. Nicardipine has a long half-life. Leaving it at higher doses may cause too low a drop in the blood pressure.

☐ **Medication Orders**: _____

_____

ADMINISTRATION OF ALTEPLASE:
☐ IV Alteplase (tPA): Give 0.9mg/kg, **maximum dose of 90mg**.
A. 0.9 mg X weight in kg = _____mg for the total dose.
Give 10% = _____mg IV over one minute.
Give 90% = _____mg IV over 60 minutes.
B. For patients who weigh more than 100kg the maximum dose is 90 mg.
Give 9 mg IV over 1 minute.
Give 81 mg IV over 60 minutes.

☐ NG, Foley, blood draws, IVs, or other invasive lines for 24 hours are contraindicated.

INTRACRANIAL HEMORRAGE (ICH) MANAGEMENT GUIDELINES:
1. Stop rtPA if there is a clinical suspicion of ICH (Neuro Deficit, Headache, HTN, N/V).
2. STAT Head CT without contrast.
3. STAT Labs: PT, PTT, Fibrinogen, Type and Cross for _____Units

4. Administer 6-8 Units Cryoprecipitate, Fibrinogen, Factor VII and 6-8 units of platelets.

Physician Signature: _____

Last Board of Directors Review: 6/19/19

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Physician Request for Consult	
Scope:	**Department:** Emergency Dept, ICU/CCU, Medical/Surgical
Source: Med/Surg Nurse Manager	**Effective Date:**

POLICY:
When a consult is ordered by a physician, the nurse receiving the order is responsible for notifying or initiating the notification if the ordering physician has not notified the consult personally.

Day Shift - The ward clerk or nurse noting the order for a consultant notification shall call the consult directly or leave a message with his/her office. The notification is noted on the Order Sheet in red with a statement or comment indicating notification.

PM or NOC Shift (consult not available at the office) - The physician requesting the consult should call the physician or indicate when the consult should be called. The ward clerk or nurse noting the order for a consult notification shall call the consult by pager or at home to notify. The notification is noted on the Order Sheet in red with a statement or comment indicating notification.

If the consult is to be called the following AM, the order should dated and a SPECIAL note in the MEMO section of nursing work card that notification "needs to be done".

For physician consultation in the Emergency Room, the ER physician notifies the physician to request a consult. This is documented on the ER record.

Committee approval needed: No, Yes
Responsibility for review and maintenance: Med-Surg Head Nurse
Index Listings: Consult, Physician Request for; Physician Request for Consult
Revised: 4/92, 2/98
Reviewed: 03/2004, 6/11RC; **9/12 BS**
Last Board of Directors Review: 6/19/19, 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Poison and Drug Overdose Information**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Perinatal, Rural Health Clinic**
Source: Pharmacy Director	Effective Date:

POLICY:
The Pharmacist will assist in providing information on antidotes to poisons and drug overdoses during regular pharmacy hours and may be called at home when on-call, if needed.

PROCEDURE:

1) Verify that the patient's physician or the Emergency Room physician has been notified of the poisoning or drug overdose immediately.

2) The Pharmacist may be contacted for information regarding antidotes to the prison exposure or drug overdose. A Supply of antidotes is available for immediate use (see attached).

3) Printed references to the treatment of poisonings and drug overdoses are located in the Emergency Room, Hospital Library, and in the Pharmacy.

4) The MSDS (Material Safety Data Sheet) file is available for information regarding the poisoning.

5) The drug manufacturer may be consulted for information and/or references for the treatment of drug overdose. Emergency telephone numbers for most manufacturers are located in the front of the PDR.

6) The California Poison Control System services Inyo and Mono Counties and should be contacted for antidote or treatment recommendations. The telephone number is available on or near all patient care area telephones.

   The telephone number for Poison Control is (800) 411-8080.
   The Poison Center is staffed 24 hours a day, seven days a week, including holidays.

		CALIFORNIA POISON CONTROL SYSTEM
HEALTH PROFESSIONALS ONLY 1-800-411-8080		
PUBLIC CALLS 1-800-876-4766		

_X_ Pharmacy Department Policy/Procedure
___ Medication Policy/procedure
Other locations for this document: Med-Surg, ER, ICU, OB
2/01/95 MK

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Poison and Drug Overdose Information**	
Scope:	Department: **Emergency Dept, ICU/CCU, Medical/Surgical, Perinatal, Rural Health Clinic**
Source: Pharmacy Director	Effective Date:

Revised: 2/25/98 kk, 3/16/98 kk, 12/00 kk, 2/01 kk
Last Board of Directors Review: 6/19/19; 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Portacath Vascular Access System	
Scope:	Manual: Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical
Source: OP/PACU Nurse Manager	Effective Date:

PURPOSE:
The PortaCath Vascular Access System is an implanted central venous access for patients requiring repeated venous access for delivery of cancer chemotherapy agents, nutritional support, IV fluid therapy, antibiotics, blood products and blood sampling.

SPECIAL CONSIDERATIONS:
Physician ordered is required.
Procedure may be performed by: _x_RN
Special education required to perform procedure:_x_ Yes; The RN managing the system shall have read the guidelines for the maintenance of the specific Portacath system

POLICY/PORTACATH GUIDELINES:
Site preparation: Always access using aseptic technique. Don a mask and have the patient turn his/her head away from the port or wear a mask as well during access. Use chlorhexidine sponge (Chloraprep) to prep the injection site.

Syringes: 10ml syringes or larger are recommended for all flushing or injection procedures.

Needle Insertion: Needles should be inserted perpendicular to the implanted septum. Insert the needle point fully through the septum until the needle point makes contact with the base of the port. Incomplete needle insertion may result in needle obstruction by the septum. Use clamps and needleless caps as needed. Do not leave system open to air although a Groshong valve (if a Groshong end is present) protects patients from blood reflux and air embolism. Do not rock or tilt the needle in either system.

Saline Flushes: Prior to drug administration, flush the system with saline solution (5ml) to remove heparin in system and check blood return to ensure patency. If more than one drug is administered, flush the systems with saline solution between drugs. After patient treatment is completed always flush the system with 10ml sterile normal saline (after medication administration) or 20ml sterile normal saline after blood sampling. The Groshong ended system is flushed with saline solution only once every 4 weeks or as necessary.

Heparin Flushing Schedule: To keep the open-ended system patent the system must be flushed with heparinized saline (after the sterile normal saline flush) once every 4 weeks and PRN. A Groshong-ended system may be flushed with saline only or heparin if desired to keep the line patent.

Heparin concentration is usually 100u/ml (5ml typical volume.) Check with physician for heparin concentration. Pediatric patients usually require heparin 100u/ml..

PRECAUTIONS:
1. Use **non-coring**, (90 degree angle) needle only.
2. For an open-ended catheter, the clamp must be closed when the system is not in use; air should not enter the system as there is no backflow flap.
3. **Never use less than 10ml size syringes** for flushing to prevent excess pressure on the Portacath. (Smaller syringes produce a higher pressure.)

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Portacath Vascular Access System	
Scope:	Manual: Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical
Source: OP/PACU Nurse Manager	Effective Date:

PROCEDURE:

ACCESS

1. Connect the syringe or IV set to a **non-coring needle infusion set** and prime tubing and needle with saline to remove air. Close clamp.

2. Don a mask and have the patient turn his/her head away from the port or have the patient don a mask as well. Locate the port septum by palpation. Prep the injection site with chlorhexidine sponge (Chloraprep), or Techni-Care if the patient has a chlorhexidine allergy.

3. Securing the Portacath septum with thumb and index finger, insert the needle into the skin over the septum, advance the needle slowly through the septum until it makes contact with the base of the port. Note: Needle must be inserted perpendicular to the septum. (see figure 1)

4. Obtain blood return. Flush with normal saline (at least 5 ml).

5. Secure with tape and clear occlusive dressing large enough to cover entire needle housing. If a winged set is used, tape wings to the side as shown. (see figure 2)

6. Open clamp and begin infusion or injection. Examine puncture site closely for any signs of subcutaneous infiltration.

7. Flush the system with saline solution **before** (at least 5ml of saline solution) and **after** each infusion or injection is completed (at least 10ml of saline solution).

Blood Sampling:

1. Use a 20 or 19 gauge non-coring needle to obtain blood samples.
2. Flush port with saline to confirm system patency. Obtain 5ml of blood and discard first blood sample. Withdraw required sample volume into new syringe. Note: If blood withdrawal is difficult:

- The distal end of catheter may be lodged against the wall of the superior vena cava.
- Usually infusion can still be performed so infuse again and then try drawing blood.
- Draw back on the syringe plunger more slowly. Follow immediately with 20 ml saline flush to cleanse the catheter and port chamber.

3. If no further treatments are required, follow flush with **heparin flush** for open-ended catheters and the valve-ended catheters only if needed.

MAINTENANCE

Follow established policy for tubing changes in IV therapy guideline (tubing every 96 hours).
Care of Insertion Site: Change dressing daily until site is well healed (then it may be left uncovered).

Title: Portacath Vascular Access System	
Scope:	Manual: Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical
Source: OP/PACU Nurse Manager	Effective Date:

To access: Cleanse site with chlorhexidine sponge (Chloraprep) or Techni-care around needle site. If Chloraprep is used allow to air dry. If Techni-care is used, wipe dry with sterile gauze. Cover site with biocclusive dressing. Label dressing with date and time of change.

FLUSHING VOLUMES:

5-10ml sterile normal saline every 4 weeks if port system is not in use.
(heparinized solution 5ml of 100units heparin/ml or as ordered for open-ended catheters)

10ml sterile normal saline after medication or nutrition infusion.
(follow with heparin sol. (5ml of 100units/ml) or as ordered for open-ended catheters)

20ml sterile normal saline after blood withdrawal.
(follow with heparin sol. (5ml of 100units/ml) or as ordered for open-ended catheters)

CLEARING A BLOCKED CATHETER:

If an unusually high resistance is detected when infusing fluid through the PortaCath, the catheter may be blocked. If this is the case, do not force fluids through the system.

Catheter blockage may due to: Kinking due to movement of the port or catheter. Occlusion by a thrombus. Incompatible drug infusions through the catheter causing formation or a precipitate.

BLOCKAGE DUE TO PORT OR CATHETER MOVEMENT:

Have patient change position and/or move upper body and arms (such body movements may move catheter enough to allow use).

Palpate port to determine if port movement has occurred.

Kinking resulting from too much or too little catheter, slack, or rotation of an inadequately anchored port, may require surgical correction.

BLOCKAGE DUE TO NEEDLE PLACEMENT OR OCCLUSION:

Reposition needle.

If blockage does not clear, call the attending physician. Alteplase may be ordered for declotting purposes; follow Alteplase policy/procedure.

DEACESSING NON-CORING NEEDLE:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Portacath Vascular Access System	
Scope:	Manual: Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical
Source: OP/PACU Nurse Manager	Effective Date:

The "Gripper Plus" Porta-Cath needle is removed in the following manner:

- Wash Hands and put on non-sterile gloves.
- Remove all tape and dressings.
- Using one hand, secure the sides of the needle system with the thumb and middle fingers.
- Pull up on the center level of the "Gripper Plus" slowly and evenly.
- When a click is heard – the needle has locked into place and it is safe to remove needle set.
- Dispose of immediately in a "sharps" container holding it by the top of the needle set. If a click is not heard – continue to pull the middle (needle) lever until the click is audible. This is important to prevent an accidental needle stick.
- Apply pressure, if needed, with a sterile 2X2 gauze pad and when bleeding has stopped, cover site with a bandaid.

DOCUMENTATION:
Document in nursing record appropriate to your department.

Committee approval needed: ___ no, __X_ yes Nurse Management 10/98
Responsibility for review and maintenance: OPD/PACU Nurse Manager
Index Listings: Portacath Vascular Access System. Central Venous Catheter: Portacath Vascular Access System. Revised: 9/98, 2/99, 2/04, 2/10 AW, 05/11AW, 3/12aw
Last Board of Director review: 1/17/18; 1/16/19; 6/19/19, 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Potassium Intravenous Administration**	
Scope:	Department: **Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, PACU, Perinatal, Surgery**
Source: Director of Pharmacy	Effective Date:

PURPOSE:

To ensure the safe administration of intravenous potassium

POLICY:

1. Potassium solutions shall be administered via IV Pump only.
2. Any IV bag containing less than 500ml shall contain no more than 20 mEq potassium.
3. IV bags containing 500ml or more shall contain no more than 100mEq per bag.
4. The rate of administration of potassium shall be no more than 10 mEq per hour unless the patient is monitored by telemetry.
5. Patients receiving more than 10mEq/hr. shall be on telemetry. This includes patients receiving total parenteral nutrition.
6. The maximum rate of infusion without the presence of a physician shall be no more than 20mEq/hr. An infusion greater than 20mEq/hr. may be administered if the MD is present during the administration.
7. The pharmacy shall stock pre-mixed, ready to administer solutions available from IV solution manufacturers containing various amounts of potassium for administration at NIH. Only a pharmacist shall mix any IV solution containing electrolytes that are not available pre-mixed. See "Concentrated Electrolytes After Hours Policy."
8. **Documentation:**

Documentation of the infusion will be on the eMAR or on the intravenous infusion area of the unit record. Any necessary note such as reaction or dysrhythmia will be in the focus notes on the PCFS.

Special Considerations:

Physician order required: yes X
Procedure may be performed by: __X_ RN _X_ LVN (per scope of practice)
Special education required to perform procedure: Familiarity and compliance with this policy
Age specific considerations: None for concentration, only dose adjustment

Committee Approval	**Date**
Policy and Procedure Committee	3/24/04
Pharmacy and Therapeutics Committee	
Medical Executive Committee	
Board of Directors	6/19/19
Last Board of Directors Review	3/18/2020

Revised 9/07
Reviewed 9/09jk, 06/11 rs
Supercedes 4/98

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Potassium Intravenous Administration**	
Scope:	Department: **Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, PACU, Perinatal, Surgery**
Source: Director of Pharmacy	Effective Date:

Administration of Intravenous Potassium
Supplemental Information

EXAMPLES

Any IV bag containing less than 500ml shall contain no more than 20 mEq potassium.

- **For example, if the MD orders 40 mEq KCL in 100ml over 4 hr. it will need to be mixed in 2 piggybacks**

The rate of administration of potassium shall be no more than 10 mEq per hour unless the patient is monitored by telemetry.

- **For example, the maximum rate of administration of a solution containing 80 mEq KCL per liter would be 125ml/hr.**
- **For a solution containing 30 mEq Potassium Phosphate per liter the maximum rate would be 333ml/hr.**

PRE-MIXED KCl SOLUTIONS AVAILABLE AT NIH

BASE SOLUTION	AVAILABLE WITH KCl ___ mEq
NORMAL SALINE	20mEq, 40mEq
D-5-W	20mEq, 40mEq
D-5 ½ N.S.	10mEq, 20mEq, 30mEq, 40mEq
D-5 ¼ N.S.	20mEq
D-5 LR	20mEq
STERILE WATER **50 ml**	10 mEq
STERILE WATER **100ml**	20mEq

INDEX LISTING: Potassium Chloride Infusion, IV Potassium

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Pregnancy Loss Specimens**	
Scope:	Department: **Emergency Dept, Pathology, Rural Health Clinic**
Source: Rita Young	Effective Date:

For P.O.C., stillbirths, placenta etc., that the physician has requested work ups on, please place specimen in ***sterile saline solution,*** and deliver to the Pathology Department. If it is after hours, please put specimen in refrigerator, and leave note to Pathology Staff informing us of the specimens whereabouts. Also be sure to include with all specimens the Pathology Request slip. This slip must be complete including specimen type, gestation, etc.

If the above mentioned specimen is not intended for work ups, then the specimen can be handled as any other surgical specimen by adding Formalin, which can be obtained from Surgery. These also can be delivered to the Pathology Department with a completed Pathology slip. If it is after hours, it is safe to leave specimen at room temperature.

Last Board of Directors Review: 6/19/19

Pathology 12/2001

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Pre-Hospital Care Policy	
Scope: Emergency Department	Manual: Emergency Department – Communication (COM)
Source: MNGR ED DISASTER PLANNING	Effective Date: 11/1/17

PURPOSE:
To define Northern Inyo Healthcare District's (NIHD) role and requirements as a Base Station Hospital.

POLICY:
NIHD has agreed to be a base station for Inyo County and will follow the protocols and standards set forth by Emergency Medical Services Agency (EMSA) also known as Inland Counties Emergency Medical Agency (ICEMA). And adhere to the requirements as set forth by Title ZZ (Refer to 100174. Paramedic Base Hospital of ALS manual.)

Medical Direction to the Advanced Life Support (ALS) personnel may only be given via two-way radio or telephone communication by the Emergency Department Physician or by a certified Mobile Intensive Care Nurse (MICN). ALS and BLS report may be received by non-MICN Registered Nurses when an MICN or ED Physician is unavailable. In the event that medical direction is requested or required, the non-MICN will locate an MICN or ED Physician. At no time will a non-MICN give medical direction or orders to BLS or ALS units.

PROCEDURE:
RECORD KEEPING
The *Base Station Hospital Mobile Intensive Care Record* will be completed by the Emergency Department personnel during all ALS and BLS calls. The *Incident #* will be the next sequential number from the previous run on the *Base Station Facility Log*. All vital signs, assessments, medications, and procedures completed prior to Base Station contact will be designated as "PTC" (prior to contact). All calls will be saved on a computer file for a minimum of 19 years.

All record keeping and submission of monthly reports to ICEMA is the responsibility of the Pre-Hospital Liaison Nurse or Nurse Manager/Assistant Manager.
Northern Inyo Hospital will follow all Quality Improvement and audit requirements as established by ICEMA/EMSA.

EMS RADIO
There are two EMS radios, Telex-IP2002 in the ED. The first one is located in the Nurse's station of the ED and has one channel for EMS radio traffic and one channel for EMS phone traffic. The second radio is located in the ED Physician room and has one channel for EMS radio traffic and one channel for the TAC channel utilized by the Unified Command.
There are six BK narrow-band radios in the ED with EMS Silver Peak, EMS Local, Fire Tac, and NIHD Maintenance channels.

REFERENCES:
1. EMSA Administrative Manual and EMS Protocols

CROSS REFERENCE P&P:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Pre-Hospital Care Policy	
Scope: Emergency Department	Manual: Emergency Department – Communication (COM)
Source: MNGR ED DISASTER PLANNING	Effective Date: 11/1/17

Approval	**Date**
CCOC	8/28/17
ER Committee	9/13/17
MEC	10/3/17
Board of Directors	10/18/17
Last Board of Directors Review	6/19/19

Developed: 2/95
Reviewed: 6/11as; 2/15as; 7/17gr
Revised:
Supersedes:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Propofol Use In Critical Care Areas**	
Scope:	Department: **Emergency Dept, ICU/CCU, PACU**
Source: Pharmacy Director	Effective Date:

PURPOSE:

To delineate policies for the safe administration of continuous intravenous infusion of Propofol (Diprivan), a sedative and anesthetic that can be administered to intubated patients in the ICU/CCU/PACU units and Emergency Department

POLICY:

1. A physician's order must be obtained before the administration of Propofol (Diprivan). The order must, at a minimum, state that propofol is to be infused to achieve deep sedation per this protocol. Note: The desired maintenance level of sedation is based on the patient's hemodynamic and pulmonary status. **The lowest possible dose of Propofol (Diprivan) should be used to sedate the patient, yet maintain hemodynamic and pulmonary stability. See Dosage in PROCEDURE.**
2. Propofol (Diprivan) orders shall be rewritten by a physician every twenty-four (24) hours.
3. Bolus injections of Propofol (Diprivan) may only be administered by a physician. Registered nurses may only administer/titrate Propofol (Diprivan) infusions.
4. Strict Aseptic technique must always be maintained during the handling of Propofol (Diprivan) in order to retard the growth rate of microorganisms. Propofol (Diprivan) does NOT contain preservatives therefore, do not use if contamination is suspected.
5. Patients receiving maintenance infusions of Propofol (Diprivan) will be awakened a minimum of every 24 hours to assess their respiratory, hemodynamic and neurological functions. These evaluations of sedation level are required to ensure that the patient receives the lowest effective dose of Propofol (Diprivan).
6. Propofol (Diprivan) does not provide analgesic effect. The patient's pain is to be adequately managed using alternative methods.
7. The physician and registered nurse will be aware that long infusions of Propofol (Diprivan) (10 days) results in the accumulation of significant tissue storage of this drug.
8. Evaluations of sedation level will be made using the Modified Ramsay Scale (see PROCEDURE for scale).
9. Propofol (Diprivan) infusion should NOT be increased to control respirations. Rather, notify the physician for consideration of a second agent.
10. Stop Propofol (Diprivan) Infusion in cases of unexplained acidosis or arrhythmias and notify physician.
11. Obtain daily blood gases and triglycerides during infusion.
12. Notify the Dietitian of any patients requiring Propofol (Diprivan) continuous IV drip for >48 hours.

PROCEDURE:

1. Gather Equipment:

a. Diprivan (Propofol) 500mg/50ml (10mg/ml) vial
b. Alcohol prep pads
c. IV PUMP tubing
d. Sterile gloves
e. IV infusion pump

2. Open vial using strict aseptic technique with sterile gloves.
3. Disinfect vial rubber stopper with alcohol prep pads.
4. Spike glass vial with universal adapter pin.
5. Connect IV tubing to universal adapter pin and prime line.

DOSAGE

6. On the unit computer select the "Standard Mix Calculator"
7. Click the "PROPOFOL" tab
8. Enter the patient's weight in pounds or in kilograms. Note: The standard mix calculator will populate the initial rate for non-debilitated and debilitated patients, rate adjustment increments for debilitated and non-debilitated patients and a suggested maximum maintenance dose for each type of patient.
9. Print the page by clicking the printer icon.
10. Have the physician sign the page (it becomes the order for propofol) and place the signed sheet in the physician order section of the chart.
11. Place IV on infusion pump and set infusion rate in accordance with the standard mix calculator.
12. Monitor patient for early signs of significant hypotension or cardiovascular depression, shock, hepatic or multi-organ dysfunction. (Use with caution.)
13. Initiate and maintain Propofol (Diprivan) dosing as follows:
14. Begin infusion at 5 mcg/kg/min or 4 mcg/kg/min if the patient is debilitated or >55 years old.
15. Increase infusion rate by increments of 5 mcg/kg/min (or at 4 mcg/kg/min if patient is debilitated or >55 years old) every 5 minutes until desired level of sedation is achieved while maintaining pulmonary and hemodynamic stability.
16. Wait at least 5 minutes between dosage adjustments to allow for onset of maximal sedative and hemodynamic effects. (Be aware that Diprivan should be initiated slowly in order to minimize hypotension.)
17. Monitor patients for early signs of significant hypotension or cardiovascular depression. (Patients with compromised myocardial function, intravascular volume depletion or abnormally low vascular tone such as sepsis, may be susceptible to hypotension).
18. Decrease the Propofol (Diprivan) infusion rate in increments of 5 mcg/kg/min at 10 -15 minute intervals:
    a. If significant hypotension develops

b. If unacceptable high triglyceride levels develop
c. When sedation is no longer needed
d. Whenever there is a BIS score of < 40 (EEG suppression) or a Ramsey score of 6 (Pt has no response to firm nail pressure or other noxious stimuli), **notify the MD when prolonged deep levels of sedation occur.**

19. If clinically significant hypotension or cardiovascular depression occurs may decrease rate more rapidly or turn it off as needed – notify the physician.
20. Continue IV drip at no greater than 50 mcg/kg/min. Obtain a physician's order for maintenance doses higher than 50 mcg/kg/min.
21. **Change IV tubing and discard any unused portion of Propofol (Diprivan) every 12 hours** in order to avoid contamination. (Rationale: Emulsion supports rapid growth of microorganisms; therefore STRICT aseptic technique is imperative). If a clave is used for infusion this should be changed after Propofol is discontinued.
22. Do not infuse Diprivan in the same line with other medications. Do NOT infuse Propofol (Diprivan) through a central line manifold (commercially prepared 3 stopcocks molded together).
23. Determine the level of sedation while a patient is on a continuous infusion every hour and as necessary and record. The level of sedation recorded will be obtained from the Modified Ramsay Scale.

Modified Ramsey Scale	
Level 1	Patient anxious, agitated, or restless.
Level 2	Patient cooperative, oriented, and tranquil
Level 3	Patient responds to command only
Level 4	Patient responds to gentle shaking.
Level 5	Patient responds to noxious stimulus.
Level 6	Patient has no response to firm nailbed pressure or other noxious stimuli.

24. Perform a **daily wake-up assessment** (unless ordered otherwise by physician) on patients remained on a Propofol (Diprivan) infusion for greater than 24 hours; document results.
    a. Avoid waking the patient too quickly. Titrate the infusion rate down slowly **(reduce @ 5mcg/kg/min in 10-15 minute increments)** so that the patient awakens slowly. Adjust the infusion rate so that the patient achieves a light hypnotic state level 2-3 (cooperative, oriented & tranquil or responds to command only) **as long as the patient's pulmonary and hemodynamic status remains stable**.
    b. Notify the physician and document the level in which the patient can be awakened before pulmonary or hemodynamic instability occurs.

Title: **Propofol Use In Critical Care Areas**	
Scope:	Department: **Emergency Dept, ICU/CCU, PACU**
Source: Pharmacy Director	Effective Date:

c. After determining the patient's awakened level of orientation, titrate the infusion rate by **increasing the infusion in 5 mcg/kg/min increments at 10 minute intervals** until the desired maintenance level of sedation is achieved.

25. Document the following:

a. The baseline level of sedation BEFORE awakening:

b. The dosage of Propofol (Diprivan) when the baseline sedation level is evaluated

c. The vital signs, oxygen saturation, ECG reading, respiratory, and hemodynamic status when the baseline sedation is evaluated.

d. The awakened level of sedation:

e. The dosage of Diprivan when the awakened sedation level is evaluated.

f. The vital signs, oxygen saturation, ECG reading, ability to move extremities, respiratory and hemodynamic status of the patient when the awakened level of sedation is recorded.

g. The patient's tolerance to awakening.

h. The maintenance level of sedation is observed and recorded every hour and as necessary.

i. The vital signs, oxygen saturation, ECG reading, respiratory and hemodynamic status of the patient with each hourly reading.

j. Date and time the initial infusion was hung and all subsequent infusions.

k. Any physician notification.

Committee Approval	**Date**
Policy and Procedure Committee	10/12/2006
Surgery,Tissue, Transfusion and Anesthesia Committee	8/30/2006
Emergency Department Committee	11/13/2006
Medical Service Committee/ Intensive Care Committee	7/27/2006
Pharmacy and Therapeutics Committee	10/12/2006
Executive Committee	12/5/2006
Board of Directors	1/17/2007
Last Board of Directors Review	3/18/2020

Revised
Reviewed
Supercedes New 7/06
Index Listings: Propofol Use In Critical Care Areas; Propofol,Sedation; Rapid Sequence Intubation

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Quality Assurance Review Daily Chart Review**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

PURPOSE:
To provide periodic review of each ER physician's rendering of patient care.

POLICY:
Quality Assurance in the Emergency Department will be maintained by pre-established indicators. These indicators will be reviewed by the ER Committee and revised as needed.

SPECIAL CONSIDERATIONS:
Physician order required: _X_ No; ___ Yes
Procedure performed by ___ RN, ___ LVN, ___ ER Tech
Special education required: _X_No; ___ Yes

POLICY:
1. Daily check of every patient's chart by nursing and physician staff for completeness and concurrence of all lab results with the ER physician's interpretation to assure:
   a the appropriateness of antibiotics against culture and sensitivity results;
   b. the correct interpretation by the ER physician of all lab, X-ray, and EKG results.
2. Focused quality assurance review by the ER physicians of all charts that meet the criticial indicator criteria.
   a. completeness of history and physical
   b. appropriateness of laboratory and X-ray examinations.
   c. consistency of diagnosis with work-up.
   d. appropriateness of therapy and treatment.
   e. and adequacy of patient instructions and follow-up.

   These charts will be logged by the ED Manager and distributed randomly to all of the physicians in the group. Physician comments will be conveyed to the physican of record. In the event that any inappropriate care has been rendered to a patient, the E.R. physician has the responsibility to take corrective action, copy the chart and note his disagreements on the copy for the involved physician, registered the general nature of the problem in the ongoing log, and notify the Emergency Room Director in those cases where a serious problem is felt to exist – that is, where a negative patient impact is likely to occur.

3. Periodic review of each E.R. physician's rendering of patient care, and the comments in the ongoing quality assurance log by the E.R. Director, with appropriate action or counseling where

Title: **Quality Assurance Review Daily Chart Review**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

necessary.

4. All emergency room patient charts, in which there have been any complaints, whether filed by patient or staff, or those in which resuscitation measures were required for the patient, or in which the patient died, and those charts that meet the Critical Indicators will be reviewed at the Emergency Room Committee meeting, and appropriate action will then be taken as decided by the Emergency Room Committee.

5. Drug usage in the Emergency Room will be overseen through the following mechanisms:
   a. Stocking only of standardized medications and antibiotics on a generic basis as approved by the Emergency Room Committee and Pharmacy.
   b. Policies and procedures for use of prophylactic antibiotics such as in open fractures, multiple trauma and animal bites.
   c. Culture and chart reviews as outlined in 1 through 4 above.

6. Periodic formal review, separately or in conjunction with other hospital services to review charts for conformance to pre-established criteria will be performed when indicated by any of the mechanisms above.

7. The Emergency Room Committee will provide perodic reports to the Quality Assurance Coordinator via the Emergency Room Committee minutes. The committee will also provide formal quarterly evaluation of services reports to the Coordinator.

8. The Chief of the ER Service is on-call 24 hours/day for patient or personnel problems requiring immediate attention. In his absence, the Associate Director of the ER and the contracted medical group, along with the Chief of Staff and Hospital Administrator will be consulted as needed.

Committee Approval Needed: Yes, Emergency Room Committee (approved 2/26/86)
Responsibility for Review and Maintenance: ER Head Nurse
Index Listings: Quality Assurance: Daily Chart Review; Daily Chart Review; Physician Chart Review
Reviewed/Revised: 2/86; 6/90; 2/01, 09/11as
Last Board of Director review: 7/18/18; 6/19/19

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Quality Improvement Program Pre-Hospital**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

PURPOSE:
To provide a standardized guideline for the assessment, ID, evaluation to improve the EMS system and maintain continuous quality improvement.

POLICY:
To follow and maintain on-going records ensuring compliance to the requirements set forth in the EMS Quality Improvement Plan.

SPECIAL CONSIDERATIONS:
Procedure may be performed by _x_ RN/MICN, _x_ PLN, _x_ Base Station Director, MD,
_X_ Physician
Special education required: _x_ Yes, knowledge of pre-hospital policy and procedure.

PROCEDURE: **REVIEW OF PATIENT CARE DATA**

A. Review of monthly MICN reports to comply with Q.I. protocol as possible

All reports that include:
scene time greater than 20 minutes and/or,
delay in transport greater than 10 minutes

will be reviewed.

All reports will be reviewed for:
complete documentation
pre-hospital care treatment orders
compliance with protocol

B. ALS Run report forms will be reviewed monthly to comply with Q.I. protocol as possible.

All reports will be reviewed for:
complete documentation
compliance with protocols
execution of Base Hospital orders

C. Tape review will be completed and reviewed for determination of cause and logged in the Quality Improvement Report, and submitted to the local EMS Agency.

1. When case review request is submitted.

2. Any call where an EMT-P was ordered by a physician to administer a medication or perform a skill out of scope of practice or in deviation from protocol.

Title: **Quality Improvement Program Pre-Hospital**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

D. Base Analysis Session

The Base Hospital will hold 2 hours of multidisciplinary Analysis (may be based on case review - see EMS Q.I. plan).

E. Concurrent Retrospective Clinical Review Reports

The EMS Agency Quality Improvement Committee may select a clinical topic on a quarterly basis to be audited by the Base Hospital and ALS providers.

F. Base Hospital Logs

These will be kept as on-going logs for periodic reviews by the EMS agency staff. Requirements for documentation in this log are included on the Base Hospital Log form.

G. Case Review Report

These will be confidential and maintained by the PLN or Base Hospital Director. They will be kept in a confidential file. Refer to EMS Q.I. Plan Case Review forms and confidentiality.

H. Radio Communication Failure

The Base Hospital Medical Director or Pre-Hospital Liaison Nurse will be required to investigate all radio communication failures as is set forth in the EMS Quality Improvement Plan. These records will also be confidential. A log shall also be kept as outlined.

Reference: EMS Quality Improvement Program 2/95 - Administrative Manual
Committee Approval Needed: No
Responsibility for review and maintenance: E.R. Nurse Manager, Pre-Hospital Liaison Nurse or Designee
Index Listings: EMS Quality Improvement; Quality Improvement EMS; Pre-Hospital Quality Improvement Program
Initiated: 3/95, 02/01; 2/15as
Last Board of Director review: 7/18/18; 6/19/19

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Quality Improvement Program Pre-Hospital**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Quality Management Program Emergency Service**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

Definition of Quality Patient Care: The degree to which patient care services increase the probability of desired outcomes and reduce the probability of undesirable outcomes, given the current status of knowledge.

OBJECTIVES:

1. To objectively and systematically monitor and evaluate the quality and appropriateness of patient care on the Emergency Service.
2. To identify problem areas and opportunities for improvement.
3. To develop corrective action programs and implement when appropriate.
4. To document corrective actions taken.
5. To evaluate the effectiveness of the corrective action using follow up devices.
6. To ensure appropriate dissemination of quality improvement information.

RESPONSIBILITIES OF SERVICE CHIEF AND COMMITTEE CHAIRMAN EMERGENCY SERVICE

The chief or the Emergency service in conjunction with the Emergency Room Head Nurse shall be responsible for:
1. Implementing the monitoring and evaluation process on a prospective and retrospective basis.
2. Resolving identified problems.
3 Providing direction and guidance to the Emergency committee in complying with the quality improvement program.

RESPONSIBILITIES OF THE EMERGENCY COMMITTEE

This committee will:
1. Delineate the scope of care provided within the Emergency Room unit.
2. Develop critical indicators to be used as screening devices in reviewing the care administered in this department.
3. Establish thresholds used to trigger physician review after cases have been isolated using the critical indicators.
4. Collect and organize this data.
5. Identify areas for improvement
6. Evaluate the appropriateness of the care administered.
7. Determine appropriate action for identified problems.
8. Report all incidents and actions taken by this committee to the quality improvement committee.

SCOPE OF CARE

The Emergency unit will be available on a twenty-four hour basis for patients requiring services relating to Urgent and routine patient care when standard care is not available through physicians offices.

Guidelines will be developed recommending which high-risk conditions should require consultation or transfer to tertiary care centers. Examples: Neurologic Injury, Certain Ophthalmic and E.N.T. injuries for which specialized care and therapies are indicated.

Q.2

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Quality Management Program Emergency Service**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

The Northern Inyo Hospital Emergency Room, which is a Basic Emergency Service, treats patients of all ages with acute, chronic and potentially life threatening conditions. Goals consist of stabilization, diagnosis, and treatment . The E.R. Unit has full equipment and facilities for emergency acute care of the critically ill patient and serves as the Base Station for Inyo County. Following initial stabilization patients may be transferred to the I.C.U., Surgery, or other hospital service.

Cardiac and neurology patients requiring extensive therapies or patients requiring specialty care not represented on the medical staff, may be immediately transferred to an appropriate Medical center; following consultation with a physician at another facility.

Management of the Emergency Room is a joint function of the Medical Staff and the Nursing Department. There is 24 hour in-house coverage by the Emergency Medicine Service Physicians and 24 hour R.N. position staffing with a E.R. Technician on duty 16-20 hours daily. The E.R. Head Nurse supervises the nursing staff who are specialty trained, all permanent R.N. staff are M.I.C.N. certified.

The Emergency Department works closely with the Respiratory Therapy, EKG, Laboratory, and Radiology services to provide quality patient care.

In addition to Emergency Room staff physicians all Northern Inyo Hospital Physicians have the option of seeing their patients in the emergency room, following established Emergency room standards. All Emergency Physicians credentials and privileges are reviewed and renewed annually. Services include basic and; Advanced Life Support, Advanced Trauma Support and standard emergent care services, as necessary.

Services include, but are not limited to: Invasive homodynamic monitoring, cardiac monitoring ventilator support, multiple drug therapies and Patient / family education. The Emergency facility has one major treatment room with 2 fully equipped patient care stations, each station is supplied with monitor defibrillator, oxygen, and suction and full cardiac resuscitation cart, tube thoracostomy, tracheostomy, and open chest trays and Base Station communication equipment. The minor procedure room has supplies for ocular and gynecology care. Also available is a fully equipped observation or holding area, , shared with Out patient services, that is equipped with patient call buttons for patients who are not yet ready for release from the hospital and may need less intensive but continuing observation or care. ER utilizes room 29-1 for overflow patient requiring less observation or care and observation over a longer time period, more critical patients may also use this room if staffing is available for necessary observation.

IMPORTANT ASPECTS OF CARE:

1. Diagnosis and stabilization of cardiac, respiratory and trauma conditions and transfer as appropriate to another service or facility.
2. Directing pre-hospital care via Base Station Radio.
3. Wound management and follow up care.
4. Diagnosis and management of Orthopedic injuries.
5. Diagnosis and treatment of infectious disease processes.
6. Diagnosis and initial work up of altered states of consciousness.
7. Diagnosis and management and if needed referral of E.E.N.T. diseases or injury
8. Medical clearance of mental health, 5150 , patients.
9. Provision of physical exam in abuse and rape situations.
10. Evaluation and early treatment and referral as needed of Obstetric/Gyn. emergencies
11. Accuracy of diagnosis and therapy.
12. Accurate administration of medication, transfusions and treatments.

Title: **Quality Management Program Emergency Service**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

13. Appropriate consultation will be obtained as appropriate and available.

CRITICAL INDICATORS:

1. All non 5150 transfers
2. Consult delay greater than 1 hour
3. Improper or lack of consent for invasive procedure
4. Level IV patients in ER over 3 hour
5. Formal patient complaints
6. Patients refusal of treatment, leaving AMA or elopement
7. Unscheduled return or admit of ER patient seen within 48 hours
8. Unscheduled ER visit of patient discharged within 72 hours (for referral)
9. All Codes, Deaths and Critical patients
10. Nosocomial infections (for referral)
11. Concern regarding quality of pre-hospital care
12. Death within 24 hours
13. Proper consultation not obtained
14. Complicated or Traumatic Airway Management
15. Laceration repair, recheck concern

EDUCATIONAL TOPICS

1. Potential COBRA violations
2. Analgesia administration which
   a. Results in need for respiratory assistance
   b. LOC decreases and patient not able to be verbally aroused
   c. Deviates from policy
3. C-spine clearance
   a. Which deviates from guidelines
4. Mental Health consultation concerns
5. EKG discrepancies
6. Other physician concerns

THRESHOLDS FOR EVALUATION - Presently 100% of all cases listed under critical indicators

COLLECTION AND ORGANIZATION OF DATA

- Concurrent chart review
- Incident reports
- Infection control reports
- Patients complaints/questionnaires
- Direct observation
- Quality Management indicator flow sheets

EVALUATION OF CARE

- Preliminary screen by ER Head Nurse and QI Coordinator
- Review by ER Chairman, Service Chief, or Designated physician
- Peer Review at ER Committee
- Identification of possible causes for inappropriate care:
  - Lack of knowledge or skill
  - Knew what to do, but did not do so
  - Equipment deficiency

Title: **Quality Management Program Emergency Service**	
Scope:	Department: **Emergency Dept**
Source: Emergency Dept Nurse Manager	Effective Date:

- Deficiency in chart documentation
- Policy/procedure violation
- Inappropriate delay in problem management
- Infection control violations
- Inappropriate diagnostics and therapies
- Inappropriate utilization of hospital or medical staff services

ACTION TAKEN

After a problem and cause is identified:

- Identify who or what needs to change
- Identify who is responsible to implement the change
- Identify appropriate action for problem cause, scope, and severity
- Identify goal for when change will occur
- Establish monitoring program for the specific problem within concurrent review
- Determine when follow up monitoring is to be evaluated
- Document all of the above in perinatal committee minutes
- Report incident and action taken to the quality assurance committee

ASSESS ACTIONS AND DOCUMENT IMPROVEMENT

Evaluate concurrent monitoring at predetermined time to assess success or failure of action taken

- If successful and problem appears resolved, continue monitoring and evaluation to ensure maintenance of quality of care.
- If failure, re-evaluate problem and determine what action needs to be taken, with subsequent use of monitoring and evaluation process.
- Document results in the ER committee minutes.

COMMUNICATION OF RELEVANT INFORMATION

If the above process is thoroughly completed, and the problem continues to exist without expected improvements, the appropriate quality improvement information will be reported to the Quality Improvement Coordinator and the Executive/Quality Improvement committee for further evaluation and action.

Responsibility for Review and Maintenance: Quality Improvement Coordinator
Index Listings: Scope of Care in Emergency Services; Quality Management Emergency Services
Reviewed/Revised: 9/98, 03/02; 2/15as
Last Board of Director review: 7/18/18; 6/19/19

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Radiation Policy for Management of Patients with Excessive Exposure**	
Scope:	Department: **Administrative, Emergency Dept, ICU/CCU, Medical/Surgical, Surgery**
Source: Radiology Director	Effective Date:

Management of Patients exposed to excessive Ionizing Radiation

IF IN CRITICAL CONDITION, PERFORM LIFE SAVING MEASURES BEFORE DECONTAMINATION IS CARRIED OUT, BUT WITH PATIENT AND MEDICAL PERSONNEL GOWNED AND GLOVED.

Prearrival:

Upon notification by the ambulance or rescue squad of impending arrival of a victim of radiation exposure, notify emergency room physician on duty and hospital administrator. Office of Emergency Services is notified (916-391-7716) of the radiation accident. Contact the Radiological Technologist on call and alert them to the need of a beta gamma survey detector (Geiger counter)

1. If contamination is expected, prepare a separate room or cubicle as an isolation room EXCEPT cover the floor with an absorbent disposable paper (like Chux **or** blue pad) and tape it to the floor.

2. If a separate space is not available, cover a floor area immediately adjacent to the entrance to the emergency room with absorbent paper. The area must be adequate for stretcher cart, disposal hampers and working space for professional attendants. Mark and close off this area with portable screens.

3. If dust is involved, have Maintenance shut off air circulation to prevent spread of contamination.

On Arrival:
On ambulance arrival, the responsible physician or nurse in the emergency room should:

1. Have the patient checked by Radiology Services members while on the stretcher for contamination (preferably as stretcher is removed from the ambulance) by the use of a survey-meter (beta-gamma survey detector).

2. If the patient is seriously injured, give emergency Life-saving assistance immediately.

3. Handle contaminated patient and wound as one would a surgical procedure, i.e. gown, gloves, cap, mask, etc.

4. If possible external contamination is involved, save all clothing and bedding from ambulance, blood, urine, stool, vomitus, and all metal objects (i.e. jewelry, belt buckles, dental plates, etc). Label with name, location on the body, time and date. Save each in leak proof containers (removed from all occupied areas) mark containers clearly 'Radioactive - Do Not Discard." Save all water in holding tank until proper disposal is available.

Responsibility for Review: X-ray Manager Revised/Reviewed: 2/98

Title: **Radiation Policy for Management of Patients with Excessive Exposure**	
Scope:	Department: **Administrative, Emergency Dept, ICU/CCU, Medical/Surgical, Surgery**
Source: Radiology Director	Effective Date:

5. Decontamination should start if medical status permits, with cleansing and scrubbing the area of highest contamination first. If an extremity alone is involved, clothing may serve as an effective barrier and the affected limb alone may be scrubbed and cleansed. Initial cleansing should be done with bar or liquid soap and warm water. If the body as a whole is involve or clothing generally premeated by contaminated material, showering and scrubbing will be necessary. Pay special attention to hair, body orifices and body fold areas. Remeasure and record measurement after each washing or showering.

   If wound is involved, prepare and cover the wound with self-adhering disposable surgical tape. Cleanse neighboring surfaces of the skin. Seal off cleansed areas with self-adhering disposable surgical drapes. Remove wound covering and irrigate wound with sterile water, catching and irrigating fluid in a basin or can to marked and handle as described in Rule 4 above. Each step in the decontamination should be preceded and followed by monitoring and recording of the location and extent of contamination.

6. Save physician's, nurses' and attendants' scrub or protective clothing, as described or patients.

7. The physician in attendance in the emergency room, if confronted with a grossly contaminated wound with dirt particles and crushed tissue, should be prepared to do a preliminary simple debridement. Further measurements may necessitate sophisticated wound counting detection instruments supplied by the consultant who will advise if further definitive debridement is necessary.

Decontamination of Hospital Personnel

1. Following decontamination of the last victim, all staff personnel except one individual should follow the decontamination procedure and leave the area. The procedure includes stripping to the skin with all clothes placed in a labeled plastic bag, extensive showering nth an abrasive soap, and checking for contamination nth a Geiger counter.

2. The last remaining staff person should remove all plastic sheeting and covers and place them in labeled leak proof plastic bags and stored away from all personnel.

3. The final "contaminate" staff person shall remove all clothing, drop them in a labeled bag and then double bag this bag with the help of a "clean person." The last staff person will then shower and be checked with a Geiger counter before leavingthe decontamination area.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Radiation Policy for Management of Patients with Excessive Exposure**	
Scope:	Department: **Administrative, Emergency Dept, ICU/CCU, Medical/Surgical, Surgery**
Source: Radiology Director	Effective Date:

Policy: Instructions to **All** Personnel exposed to "Intermittent Ionizing Radiation"

Procedure: In the case of all diagnostic radiography (this includes CT, Portable X-ray, Portable C-arm procedures, and all routine fluoroscopy and radiography as performed in the Radiology department) there are three primary rules to limiting your Radiation dosage. They are: Time, distance and shielding. "Although every attempt is made to limit the radiation in all procedures, operative or otherwise, the following should be adhered to:"

Time: Limit your exposure to as short a time as possible. If you are involved in surgery cases that require prolonged use of the C-arm than divide those case loads equally among your fellow workers, exclude those who might be pregnant.

Distance: Whenever possible increase the distance between you and the source of the radiation eg. (Portable or C-arm). Here is an example of how you can limit your radiation dosage significantly. If you are one foot away from the radiation source and move a distance of two feet from your radiation source your dose is cut to 1/4, if you move a distance of 4 feet from the source your dose is reduced to 1/16! This is called the Inverse Square Law and simply states that as you double the distance from any radiation source you quarter the amount of radiation received.

Shielding: Always use the Lead aprons supplied. There is NO excuse for not wearing one of these devices. The protective lead aprons supplied at Northern Inyo Hospital can effectively reduce the radiation dosage 99% to those areas covered by the apron.

Pregnant Personnel: The following facts must be considered:

1. Any unborn child, is proportionately more susceptible to the effects of ionizing radiation.
2. The long term effects of low-level radiation are not fully known.
3. Radiation exposure effects are cumulative over a person's lifetime.

Therefore, if possible, all pregnant personnel should avoid exposure to ionizing radiation.

Responsibility for Review: X-ray Manager
Index listing: Radiololy-Intermittent Ionizing Radiation Reviewed/Revised: 2/98, 9/9/09
Last Board of Directors Review Date: 1/16/19; 6/19/19, 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Recommendation for Prophylaxis After Occupational Exposure to HIV	
Scope:	Manual: Nursing All Unit
Source: Med/Surg Nurse Manager	Effective Date: June 2008

RESPONSIBILITY:

1. **Nursing Supervisor / Infection Control Practitioner (ICP) / Nurse Manager**
   a. Evaluate exposure to determine need for prophylaxis, by consultation with a physician with the HIV Hotline **(1-888-448-4911)**
   b. Initiate protocol
   c. Obtain baseline HIV and HCV baseline testing on healthcare worker (HCW) and source patient (if not already done). **Written consent is NOT required.**
   d. Provide HIV Test information sheet to HCW and source patient
   e. Contact HCW's personal MD
   f. Counsel HCW

2. **E.R.**
   a. Notify ICP, Nursing Supervisor, or Unit Manager immediately (notify I.C. Chairperson if ICP not available)
   b. Initiate Protocol
   c. Notify Pharmacy
   d. Obtain signature on "Voluntary Statement of Intent to Avoid Pregnancy" form
   e. Give this entire protocol to HCW.

3. **Pharmacy**
   a. Initiate drug protocol

4. **Employee Health**
   a. Follow up documentation in HCW file
   b. Notify Administration of comp case

5. **HCW's Personal Physician**/or Infection Control Chairperson for follow up evaluation and treatment.

RECOMMENDATION:
Exposed HCW should be informed that:
1. Most occupational exposures to HIV do not result in HIV transmission.
2. Limited knowledge is available re:
   a. efficacy and toxicity of prophylaxis in persons without HIV infection or who are pregnant.
   b. the risk of HIV infection after different types of exposures.
3. All prophylactic drugs may be declined.

POLICY:

1. Determine the need for HIV post exposure prophylaxis (PEP) after an occupational exposure.
2. Follow Step 1 to 4
3. **Drug regimes** are followed as outlined in the Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis (Occupational Exposure PEP_ CDC Guidelines 2005 just following this policy).

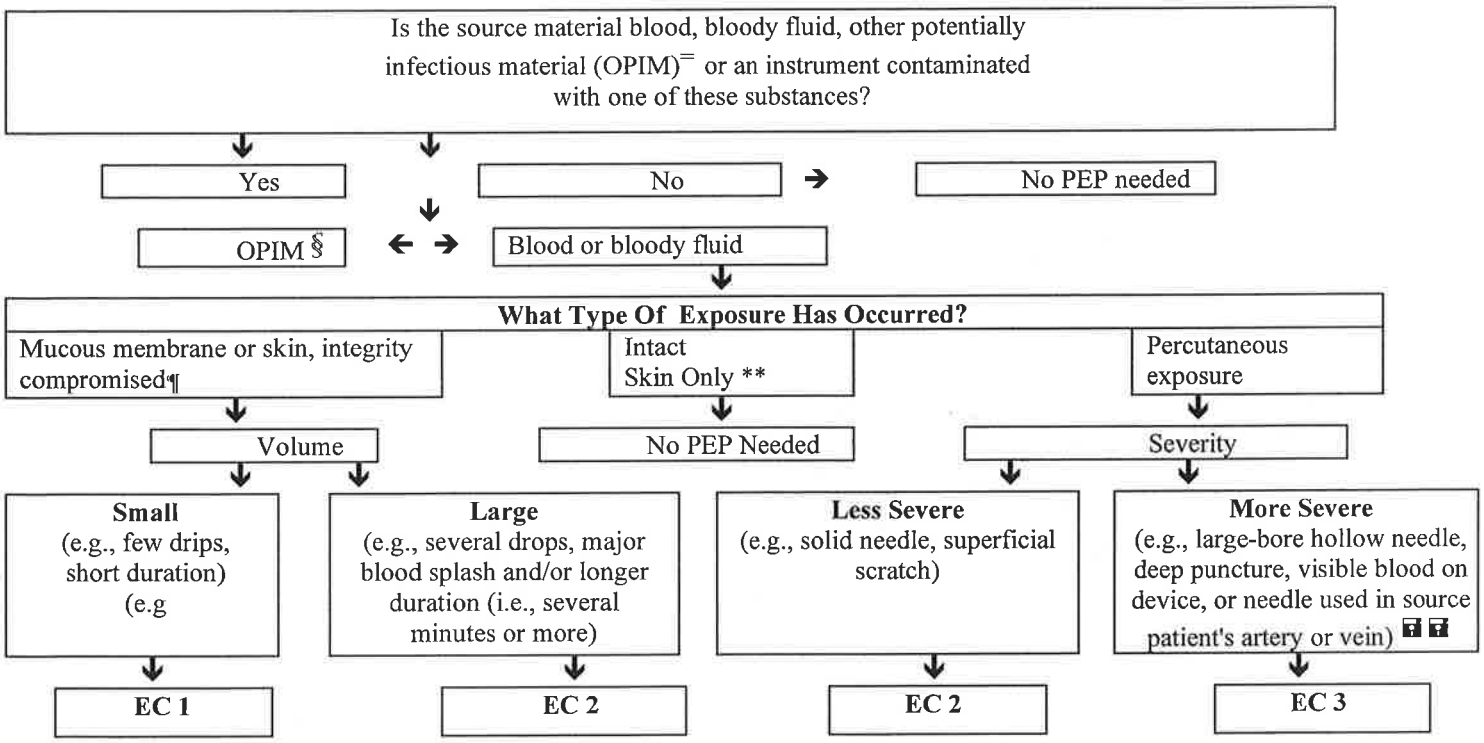
Title: Recommendation for Prophylaxis After Occupational Exposure to HIV	
Scope:	Manual: Nursing All Unit
Source: Med/Surg Nurse Manager	Effective Date: June 2008

4. Post Exposure **Prophylaxis** (PEP) should be initiated (ideally) **within 1 hour** of exposure, and at least within 72 hours. Initiation of therapy after a longer interval may still be considered depending on risk.
5. If the source **patient** is **unknown** or the patient's HIV status is not known, initiating PEP should be decided on a case-by-case basis.
6. "Intent to Avoid Pregnancy" shall be signed by HCW.

PROCEDURE:

STEP 1: Determine Exposure CODE (EC)

Determining the need for HIV postexposure prohylaxis (PEP) after an occupational exposure*



* This algorithm is intended to guide initial decisions about PEP and should be used in conjunction with other guidance provided in this policy.

= Semen or vaginal secretions; cerebrospinal, synovial, pleural, peritoneal, pericardial, or amniotic fluids; or tissue.

Title: Recommendation for Prophylaxis After Occupational Exposure to HIV	
Scope:	Manual: Nursing All Unit
Source: Med/Surg Nurse Manager	Effective Date: June 2008

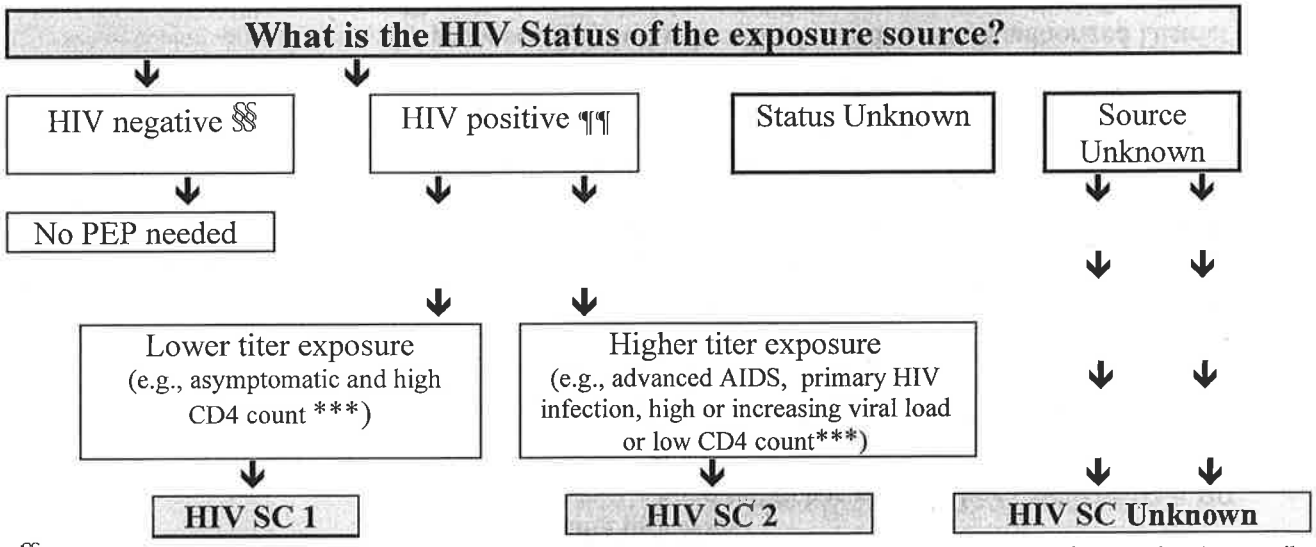
§ Exposure to OPIM must be evaluated on a case-by-case basis. In general, these body substances are considered a low risk for transmission in health-care settings. Any unprotected contact to concentrated HIV in a research laboratory or production facility is considered an occupational exposure that requires clinical evaluation to determine the need for PEP.

¶ Skin integrity is considered compromised if there is evidence of chapped skin, dermatitis, abrasion, or open wound.

** Contact with intact skin is not normally considered a risk for HIV transmission. However, if the exposure was to blood, and the circumstance suggests a higher volume exposure (e.g., an extensive area of skin was exposed or there was prolonged contact with blood), the risk for HIV transmission should be considered.

The combination of these severity factors (e.g., large-bore needle and deep puncture) contribute to an elevated risk for transmission if the source person is HIV-positive.

STEP 2: Determine HIV Status Code (HIV SC)



§§ A source is considered negative for HIV infection if there is laboratory documentation of a negative HIV antibody, HIV polymerase chain reaction (PCR), or HIV p24 antigen test result from a specimen collected at or near the time of exposure and there is no clinical evidence of recent retroviral-like illness.

¶¶ A source is considered infected with HIV (HIV positive) if there has been a positive laboratory result for HIV antibody, HIC PCR, or HIV p24 antigen or physician-diagnosed AIDS.

***Examples are used as surrogates to estimate the HIV titer in an exposure source for purposes of considering PEP regimens and do not reflect all clinical situation that may be observed. Although a high HIV titer (HIV SC 2) in an exposure source has been associated with an increased risk for transmission, the possibility of transmission from a source with a low HIV titer also must be considered.

STEP 3: Determine the PEP Recommendation

Title: Recommendation for Prophylaxis After Occupational Exposure to HIV	
Scope:	Manual: Nursing All Unit
Source: Med/Surg Nurse Manager	Effective Date: June 2008

EC	HIV SC	PEP Recommendation
1	1	**PEP may not be warranted.** Exposure type does not pose a known risk for HIV transmission. Whether the risk for drug toxicity outweighs the benefit of PEP should be decided by the exposed HCW and treating clinician.
1	2	**Consider basic regimen.** Exposure type poses a negligible risk for HIV transmission. A high HIV titer in the source may justify consideration of PEP. Whether the risk for drug toxicity outweighs the benefit of PEP should be decided by the exposed HCW and treating clinician.
2	1	**Recommend basic regimen.** Most HIV exposures are in this category; no increased risk for HIV transmission has been observed but use of PEP is appropriate.
2	2	**Recommend expanded regimen.** Exposure type represents an increased HIV transmission risk.
3	1 OR 2	**Recommend expanded regimen.** Exposure type represents an increased HIV transmission risk.
Unknown		If the source or, in the case of an unknown source, the setting where the exposure occurred suggests a possible risk for HIV exposure and the EC is 2 or 3, consider PEP basic regimen.

STEP 4: Exclusion criteria:

Health care workers will be ineligible if any of the following criteria are present:

1. HIV infection diagnosed at baseline (within 2 weeks of exposure).
2. Failure to give written informed consent prior to initial therapy.
3. Pregnant or breastfeeding women.
4. Men or women declining pregnancy avoidance.
5. Active substance abuse
6. Active malignancy, hepatic, pancreatic, or renal disease, or other illness contraindicating treatment.
7. Treatment with myelosuppressive, hepatotoxic, or nephrotoxic agents within the past four weeks.

STEP 5: Determine Dosing Regime:

1. Per recommendation of physician/pharmacist at HIV PEPLine **(1-888-448-4911)**; or
2. Per the Updated US Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis (Occupational Exposure PEP_ CDC Guidelines 2005 just following this policy).

STEP 6. MEDICAL EVALUATION/FOLLOW/UP

HCW should receive follow-up counseling and medical evaluation as follows:

1. **HIV antibody** test at baseline; 6 weeks, 12, weeks, 6 months, and 1 year, or as recommended by treating physician.

2. **Follow up evaluation** will occur 2 weeks for the first 6 weeks, then at 3 months, 6 months, 1 year or more frequently if indicated by toxicity or other concerns and will include: 337

- symptom review
- targeted physical examination
  - phlebotomy for: complete blood count
    platelet count
    liver function tests
    kidney function tests
    amylase
    serum banking

STEP 7. ADVISE OF RISKS

1. There is a risk of serious side effects associated with the drugs offered in this study.

   a. Known side effects of **zidovudine** include:

   Common: headache, muscle pain, tiredness. Loss of appetite, trouble sleeping, nausea

   Uncommon: fever, vomiting, dizziness, diarrhea, anemia, low white blood count, low platelet count, hepatitis (liver inflammation), muscle inflammation.

   b. Know side effects of **lamivudine** include:

   Common: headache, muscle pain, tiredness. loss of appetite trouble sleeping, nausea,

   Uncommon: fever vomiting, dizziness, diarrhea, anemia, low white blood count, hepatitis(liver inflammation), pancreatitis (pancreas inflammation).

   c. Known side effects of **indinavir** include:
   Common: abdominal pain, fatigue, nausea, vomiting diarrhea, headache, insomnia, changes in taste, abnormal liver tests,
   Uncommon: anemia, low white blood count, hepatitis (liver inflammation), kidney stones (nephrolithiasis), pancreatitis (pancreas inflammation)
   Indinavir cannot be taken concurrently with any of the following drugs: **seldane, hismanal, halcion, versed, and propulsid.** Serious and/or life-threatening events could occur.

2. Treatment side effects are expected to disappear after treatment is stopped, but could be life-threatening or irreversible. **The study drugs are new and there is little known about their short-term and long-term side effects when used in combination**. New or rare serious side effects, including cancer, birth defects, or other life-threatening diseases, might develop now or in the future.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Recommendation for Prophylaxis After Occupational Exposure to HIV	
Scope:	Manual: Nursing All Unit
Source: Med/Surg Nurse Manager	Effective Date: June 2008

Responsible for Review and Maintenance: Infection Control Practitioner
References:

1. CDC, MMWR Vol 54, No. RR-9, "Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to HIV and Recommendations for Postexposure Prophylaxis;" September 30, 200
2. "HIV Testing in Health Care Settings;" California Department of Public Health, January 18, 2008. http://www.cdph.ca.gov/programs/AIDS/Documents/PERILTRGenAB682Policy2008-01-18.pdf
3. California Department of Public Health, Office of AIDS; www.dhs.ca.gov/AIDS

Initiated: 9/96
Revised: 11/96; 9/99; 1/06; 4/07; 9/07; 6/08; BS 9/12; 1/17 NH
Index: Prophylaxis after Occupational Exposure to HIV; HIV Exposure, Prophylaxis Recommendation.
Last Board of Director review: 7/18/18; 1/16/19; 6/19/19; 3/18/2020

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Removal of Placenta from Hospital per Patient's Request	
Scope: Perinatal	Manual: Emergency Dept, ICU/CCU, Medical/Surgical, Nursing Administration, Perinatal, Surgery
Source: DIRECTOR OF NURSING ED AND INPATIENT SERVICE	Effective Date: 6/19/19

PURPOSE: The purpose of this policy is to provide guidance for the staff in honoring a patient's request to remove her placenta from the hospital after birth.

POLICY:

1. The placenta will be placed in a plastic container provided by the Perinatal Department
2. If the provider determines the need for placenta to go to pathology for further examination, the patient will not be permitted to take it home.
3. If the patient has a communicable disease including, but not limited to, one of the following, the placenta may not be released from the hospital:
    1. Hepatitis B, C, D
    2. HIV
4. The patient is responsible for bringing a container (ie: cooler) in which to transport the placenta from the hospital.
5. No storage will be made available for the placenta, and the patient's family/significant other will be required to take the placenta home immediately upon receipt.

PROCEDURE:

1. Don Personal Protective Equipment (PPE)
2. Ensure that the provider has assessed the placenta for intactness and that there is no indication for it to be sent to Pathology.
3. Ensure that there is no maternal disease process.
4. Place the placenta, membranes and cord in the designated plastic container.
5. Place a patient label on the plastic container.
6. Obtain Release of Liability for Removal of Placenta and have patient sign the release.
7. Instruct the patient's family or significant other on the following:
    1. Placenta must be taken home immediately from the hospital.
    2. Storage is not available anywhere in the hospital.
    3. The placenta cannot be returned to the hospital.
8. Document hand over of placenta to family or significant other in patient's electronic medical record, including instructions as mentioned above.

REFERENCES:

1.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Removal of Placenta from Hospital per Patient's Request	
Scope: Perinatal	Manual: Emergency Dept, ICU/CCU, Medical/Surgical, Nursing Administration, Perinatal, Surgery
Source: DIRECTOR OF NURSING ED AND INPATIENT SERVICE	Effective Date: 6/19/19

CROSS REFERENCE P&P: Disposal of Placenta

Approval	**Date**
Perinatal/Pediatrics Committee	5/14/19
Medical Executive Committee	6/10/19
Board of Directors	6/19/19
Last Board of Directors Review	3/18/2020

Developed:
Reviewed:
Revised: 06/19ss

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Responding to Ventilator, BiPAP, Vapotherm, EtCO2 and SpO2 Alarms	
Scope:	Manual: Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Pediatric, Perinatal, Respiratory
Source: Cardiopulmonary Manager	Effective Date:

PURPOSE:
To insure that Ventilator, BiPAP, EtCO2, Vapotherm and SpO_2 Alarms are appropriately responded to.

POLICY:
At no time shall alarms be turned off. If alarms are turned off, or not set appropriately, a Quality Review Report must be completed. Alarms must be heard at the nursing station.

PROCEDURE:
Whenever an alarm activates on a Ventilator, BiPAP or Monitoring Device, it is imperative that a clinician respond to the alert. The first issue should be patient safety. The clinician must make sure the patient is adequately ventilated and oxygenated.
The practitioner should visually assess the patient to establish level of consciousness, color, use of accessory muscles, chest wall movement, and so on. During this time the alarm can be checked and silenced.
Auscultation of the chest and viewing the SpO_2 monitor can establish the presence of breath sounds, the current heart rate, and the oxygen saturation. If the patient is in acute distress, with labored breathing, pallor, diaphoresis, and apparent anxiety, along with deterioration of breath sounds a decreasing SpO_2, or an increasing End-tidal CO_2, immediate action is required. If a serious problem is detected, the patient may need to be disconnected from the ventilator or BiPAP and manual ventilation may need to be performed with a resuscitation bag.

For the Puritan Bennett 840 Ventilator:

1. Alarms on the 840 Ventilator System are classified as high-medium-, or low-urgency:

    - *High-urgency alarms* require immediate attention to ensure patient safety. During a high-urgency alarm, the red high-urgency!!! Indicator flashes rapidly, the high-urgency audible alarm (a sequence of five tones that repeats twice, pauses, then repeats again) sounds, and the top of the upper screen flashes an alarm message. If a high-urgency alarm goes away spontaneously (auto resets), its indicator remains lit (not flashing) until you press the alarm rest key.

    - *Medium-urgency alarms* require prompt attention. During a medium-urgency alarm, the yellow medium-urgency!! Indicator flashes slowly, the medium-urgency audible alarm (a repeating sequence of three tones) sounds, and the upper screen flashes an alarm message. If a medium-urgency alarm auto resets, the indicator turns off and the auto reset is entered in the alarm history log.

- *Low-urgency alarms* tell you that there has been a change in the patient-ventilator system. During a low-urgency alarm, the yellow low-urgency! Indicator lights, the low-urgency audible alarm (two tones, non-repeating) sounds, and the upper screen displays an alarm message. If a low-urgency alarm auto resets, the indicator turns off that the auto reset is entered in the alarm history log.

Press the alarm silence key to mute the alarm sound for two minutes. A new High-Urgency alarm cancels the alarm silence and the alarm sound turns on. Each time you press the alarm silence key, the silence period resets to two minutes.

2. If any alarms sound and the Respiratory Therapist is not in the immediate area, the nurse will page respiratory and investigate the cause of the alarm. The nurse will assess the patient's respiratory effort and if necessary, remove patient from the ventilator, and will manually ventilate the patient.

For the VersaMed i Vent Ventilator:

1. The most important alarm is the Disconnect. When the patient is disconnected from the ventilator this Alarm will sound continuously and a Red Warning Dialog box will appear on the main screen. Immediately assess the patient and reconnect the ventilator tubing or manually ventilate the patient, notify Respiratory.

2. The other alarms will sound once or twice and the Red Warning Dialog Box will appear on the main screen. These alarms include, High/Low Respiratory rate, High/Low Minute Volume, High/Low Inspiratory Pressure, Apnea, High/Low FiO2.

Press the alarm silence key to mute the alarm sound for two minutes. Each time you press the alarm silence key, the silence period resets to two minutes.

For the V60 Ventilator:

1. Alarms on the V60 Ventilator are classified as High Priority, Medium Priority or Low Priority.

Alarm Tone Priorities

- High Priority alarm indicates Vent Inoperative, requires immediate attention and are indicated by repeating sequence of 5 tones, (or backup alarm) alternating tone for a minimum of 2 minutes.

- Medium Priority alarms require immediate attention and are indicated by intermittent tone at an interval of approximately 20 seconds.
- Low Priority alarms require attention as soon as reasonably possible and are indicated by repeating sequence of 5 tones.

Press the alarm silence key to mute the alarm sound for two minutes. Each time you press the alarm silence key, the silence period resets to two minutes.

For the BiPAP Vision
There are four main alarms,

- Vent Inoperative—Discontinue use; unit requires service
- Check Ventilator—the unit continues to operate, may require service
- Apnea—Patient not breathing—evaluate the patient
- Patient Disconnect—patient circuit is disconnected from the ventilator—reattach mask

The Alarm Silence hard key turns off the audible alarm for two minutes. Any further pressing of the Alarm Silence hard key has no effect on the alarm.

If any alarms sound and the Respiratory Therapist is not in the immediate area, the nurse will page respiratory and investigate the cause of the alarm. The nurse will assess the patient's respiratory effort and if necessary, remove patient from the BiPAP, and will manually ventilate the patient.

For the Vapotherm Precision Flow

1. Alarms on the Vapotherm Precision Flow are classified as Medium Priority or Low Priority.

The Mute button will silence low priority alarms for 2 minutes and medium priority alarms for 20 seconds (except for Blocked Tube alarm, which can only be muted for 5 seconds or less while the alarm resets). A yellow LED above the Mute button indicates that one or more alarms are muted.

Alarm Tone Priorities

- Medium Priority alarms require immeditate attention and are indicated by rapid intermittent tones (fast triple beats).
- Low Priority alarms require attention as soon as reasonably possible and are indicated by infrequent intermittent tones (slow double beeps).

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Responding to Ventilator, BiPAP, Vapotherm, EtCO2 and SpO2 Alarms	
Scope:	Manual: Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Pediatric, Perinatal, Respiratory
Source: Cardiopulmonary Manager	Effective Date:

For SpO_2 and $ETCO_2$ monitors:

1. If any alarm sounds and the Respiratory Therapist is not in the immediate area, the nurse will investigate the cause of the alarm, assess the patient's respiratory effort, and will insure adequate ventilation. If needed the nurse will notify Respiratory.

Press the alarm silence key to mute the alarm sound for two minutes.

Competency Validation Form to be completed. Found in Policy Manager

REFERENCES:

1. Mechanical Ventilation, Susan P. Pilbean, J.M. Cairo pg. 393
2. 840 Operator's and Technical Reference Manual OP 5-1 – 5-16
3. iVent Operator's Manual pg. 20
4. Respironics V60 Ventilator User Manual
5. Respironics BiPAP Vision Clinical Manual
6. Vapotherm Precision Flow User Manual

CROSS REFERENCE P&P:

1. Medical Clinical Alarm Equipment Safety

Approval	**Date**
Clinical Alarm Policy Committee	10/27/14
Shared Governance –or CCC	
MEC	
Board of Directors	10/16/19
Last Board of Directors Review	3/18/2020

Reviewed:
Revised:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Resuscitation Quality Improvement (RQI)	
Scope: Nursing Department	Manual: NURSING, Nursing Administration
Source: COORD DIST EDUCATION	Effective Date: 7/01/2019

PURPOSE: To insure that employees in direct patient care areas have the skill and competency to perform Cardiac Pulmonary Resuscitation (CPR) as required for employment.

POLICY: To maintain staff competency in Cardio Pulmonary Resuscitation for American Heart Association (AHA) certifications BLS, ACLS, and PALS.

PROCEDURE:

1. Newly hired patient care personnel who do not have a current AHA BLS, ACLS or PALS card with a minimum of 6 months left prior to expiration will be offered a chance to complete certification via hospital blended learning platform. The certification renewal course is to be completed during the employee orientation period, unless otherwise arranged. An exception to this would be if personnel have a current AHA certification with no less than 6 months' expiration. Personnel may elect to seek initial certification at another facility at their own expense. Once certification is obtained personnel will be enrolled in Resuscitation Quality Improvement Program (RQI), to maintain competency.

2. All patient care personnel in the nursing department and district RN's subject to mandatory cardiopulmonary resuscitation (CPR) certifications (BLS, ACLS, PALS) will be required to participate in the RQI education program in place of traditional recertification. The RQI program promotes constant competency and certification for staff through the completion of quarterly reviews, hands on demonstrations and completion of a cognitive portion within the Learning Management System. The Resuscitation Quality Improvement Program is offered continuously throughout Northern Inyo Healthcare Districts District Education department.

3. RQI is the preferred method for competency recertification of CPR skills as evidenced by Best Practice recommendations through the AHA and Laerdal. Outlined below is NIHD's RQI program.
    a) The RQI mannequin and supplies are located in the District Education Office.
    b) All patient care personnel in the nursing department and district RN's whom are required to maintain CPR certification and competency must complete quarterly compressions and ventilations using the RQI mannequin. Quarterly Schedule: January-March, April-June, July-September, October-December.
    c) Patient care personnel must complete the online cognitive portion within the learning management system (LMS) by the assigned due date.
    d) Anyone who lets their certification expire or fails to complete the quarterly competencies will be held accountable to District Policy. Process will follow the same guidelines currently in place for employees who fail to maintain required certification; staff will not be allowed to provide direct patient service until certification or competency sessions are achieved. Exceptions will be made for leave of absence (LOA) situations. Upon return to work after LOA, employee will be required to complete RQI modules prior to providing direct patient care.
    e) Certification is verified through the LMS, Nursing Administration Office, and Human Resources. Resuscitation certification and E-cards may be printed from employee LMS profile as needed. Records of completion are maintained in the employee's transcript within the LMS.

Title: Resuscitation Quality Improvement (RQI)	
Scope: Nursing Department	Manual: NURSING, Nursing Administration
Source: COORD DIST EDUCATION	Effective Date: 7/01/2019

REFERENCES:

RQI Program Overview [PDF]. (2018). American Heart Association. Retrieved from http://cpr.heart.org/idc/groups/ahaecc-public/@wcm/@ecc/documents/downloadable/ucm_496708.pdf

Resuscitation Quality Improvement Annotated Bibliography [PDF]. (2017). American Heart Association. Retrieved from http://cpr.heart.org/idc/groups/ahaecc-public/@wcm/@ecc/documents/downloadable/ucm_496707.pdf

Strategies to Improve Cardiac Arrest Survival: A Time to Act (Report Brief). (2015). The National Academy of Sciences Retrieved http://www.nationalacademies.org/hmd/~/media/Files/Report Files/2015/Cardiac-Arrest/CardiacArrestReportBrief.pdf

CROSS REFERENCE P&P:

1. Competency notebook
2. Competency policy

Approval	**Date**
NEC	2/21/18
Board of Directors	4/17/19
Last Board of Directors Review	3/18/2020

Developed: 2/18 mk
Reviewed:
Revised:

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Safely Surrendered Baby Policy and Procedure	
Scope: NIHD	Department: **Emergency Dept, Perinatal, Social Services**
Source: Emergency Dept. Manager	Effective Date: 5/1/18

PURPOSE:
This intent of this policy is to meet the legal requirements of the Newborn Safe Surrender Law (Health and Safety Code1255.7).

POLICY:

1. The Emergency Department shall be designated to be responsible for accepting physical custody of a minor child who is 72 hours old or younger from a parent or individual who has lawful custody of the child and who surrenders the child.
2. NIHD shall post a sign in the Emergency Department utilizing a statewide logo that has been adopted by the State Department of Social Services that notifies the public of the location where a minor child 72 hours old or younger may be safely surrendered.
3. A member of the ED Staff shall do the following:
    a. Place a coded, confidential ankle bracelet on the child.
    b. Provide, or make a good faith effort to provide, to the parent or other individual surrendering the child a copy of unique, coded, confidential ankle bracelet identification in order to facilitate reclaiming the child. However, possession of the ankle bracelet identification, in and of itself, does not establish parentage or a right to custody of the child.
    c. Provide, or make a good faith effort to provide, to the parent or other individual surrendering the child a medical information questionnaire, which may be declined, voluntarily filled out and returned at the time the child is surrendered, or later filled out and mailed in an envelope provided for this purpose. This medical information questionnaire shall not require any identifying information about the child or the parent or individual surrendering the child, other than the identification code provided in the ankle bracelet placed on the child. Every questionnaire provided pursuant to a safe surrender shall begin with the following notice in no less than 12-point type:

Notice: The baby you have brought in today may have serious medical needs in the future that we don't know about today. Some illnesses, including cancer, are best treated when we know about family medical histories. In addition, sometimes relatives are needed for lifesaving treatments. To make sure this baby will have a healthy future, your assistance in completing this questionnaire fully is essential. Thank You

    d. Ensure that a medical screening examination and any necessary medical care is provided to the surrendered child as soon as possible without requiring consent of the parent or other relative to provide that care to the minor child pursuant to a safe surrender.
4. After the medical screening exam is complete and the newborn is determined to be stable, or is stabilized, the newborn will be placed in the Perinatal Department Nursery, for routine newborn care.
5. A Nursing Supervisor shall be notified as soon as possible.
6. The Nursing Supervisor shall notify Social Services.
7. Social Services or the Nursing Supervisor shall notify Child Protective Services of the safe surrender as soon as possible, but no later than 48 hours after the physical custody of a child has been accepted.
8. Any medical information pertinent to the child's health, including, but not limited to, information obtained pursuant to the medical information questionnaire shall be provided to child protective services without obtaining a HIPAA release. However, any personal identifying information that pertains to a

Title: Safely Surrendered Baby Policy and Procedure	
Scope: NIHD	Department: **Emergency Dept, Perinatal, Social Services**
Source: Emergency Dept. Manager	Effective Date: 5/1/18

parent or individual who surrenders a child shall be blacked out from any medical information provided to child protective services or the county agency providing child welfare services.

9. Since child protective services will assume temporary custody of the child immediately on receipt of notice, NIHD employees will surrender physical custody of the child to the agency upon demand.
10. Should the person who surrendered the newborn request that the hospital return the newborn to him/her before child protective services assumes custody of the child, then, NIHD personnel will either return the child to the parent or individual or contact the child protective agency if NIHD personnel know or reasonably suspect that the child has been the victim of child abuse or neglect. The voluntary surrendering of a child is not in and of itself a sufficient basis for reporting child abuse or neglect. The child will not be returned to the requesting person if the hospital has been notified that a dependency petition has been filed in juvenile court.
11. The person requesting the return of the newborn must present positive identification or evidence that the requesting person is the person who surrendered the child.

PROCEDURE:

1. At the time of the presentation, attempt to verify the age of the newborn by physically examining the infant, specifically looking for presence of umbilical cord.
2. When the newborn is surrendered to the Emergency Department staff they will immediately call the Perinatal Unit and the ED physician and notify them that they have a surrendered newborn and request their assistance.
3. The Perinatal nurse will bring a radiant warmer and ID bands to the Emergency Department.
4. The ED physician will perform a "medical screening examination".
5. Notify the Supervisor and Social Service Worker of the surrendered newborn.
6. Place an identification bracelet on the infant's wrist and ankle.
7. Make a duplicate bracelet with identical numbers to give to the person surrendering the baby in case the person wants to reclaim the child at a later date.
8. The identification band will contain the following information:
    a. The infant's name or baby boy/girl Doe if no name.
    b. Tag number
    c. Sex of infant
    d. Date and time of birth, or the admit date and time if birth data is unknown
9. Ask the person surrendering the newborn to complete a family medical history questionnaire.
10. Admit the newborn to the Perinatal Department Nursery.
11. Notify the on-call pediatrician of the admission.
12. The admitting nursery nurse will follow policy and procedure for *Admit Newborn to Nursery.*

DOCUMENTATION:

1. The confidential identification will be handled per medical records guidelines.
2. The medical screening examination, treatment and transfer from the Emergency Department will be the usual documentation.
3. Discharge documentation: Social Services obtain release of minor documentation, and CPS credentials.
4. The nurse will chart according to "Surrendering to CPS Policy and Procedure.

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Safely Surrendered Baby Policy and Procedure	
Scope: NIHD	Department: **Emergency Dept, Perinatal, Social Services**
Source: Emergency Dept. Manager	Effective Date: 5/1/18

REFERENCES:

1. http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1001-1050/ab_1048_bill_20100930_chaptered.pdf
2. California Department of Social Services. (2006). *Safely Surrendered Baby Law* Retrieved from http://www.cdss.ca.gov/inforesources/Safely-Surrendered-Baby

CROSS REFERENCE P&P:

1. *Surrendering to CPS Policy and Procedure*
2. *Admit Newborn to Nursery*

Committee Approval	**Date**
Clinical Consistency Committee	1/29/18
Emergency Room Medical Care Committee	3/14/18
Medical Executive Committee	4/3/18
Board of Directors	4/18/18
Last Board of Director review	2/18/2020

Initiated: 01/2001
Reviewed: 2/15as
Revised: 12/17gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Saline Lock For Blood Draw**	
Scope:	Department: **Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, PACU, Perinatal, Surgery**
Source: ICU Nurse Manager	Effective Date:

PURPOSE:
To facilitate venous blood draws on children or adults.

SPECIAL CONSIDERATIONS:
Physician order required.
Procedure may be performed by _x_ RN, _x_ LVN
Special education required to perform procedure: _x_ Yes, LVN must have completed LVN IV certification/Blood Withdrawal class.
This is not to be used on neonates (under 1 month old)

EQUIPMENT:
IV Tray
Primed clave needleless connector extension set.
Syringe with Normal Saline
Empty syringe – size determined by Lab personnel

PRECAUTIONS:
Catheter placement is in the vein.

PROCEDURE:
1. Explain to patient what is going to happen.
2. Follow procedure for inserting and securing peripheral, saline lock, ideally 18 gauge

To Draw Blood:
1. Flush catheter with 1 ml of N.S.
2. May need to apply tourniquet above catheter site, or reposition arm to provide good venous flow.
3. Attach a 3 ml syringe to the clave, gently aspirating 2-3 ml of blood – discard syringe.
4. Reattach desired syringe size and gently aspirate required amount of blood needed for lab test.
5. Release tourniquet (if used), dispose of syringes as per hospital policy.
6. Gently flush clave connector with 3 ml of N.S.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Saline Lock For Blood Draw**	
Scope:	Department: **Emergency Dept, ICU/CCU, Infusion Center, Medical/Surgical, PACU, Perinatal, Surgery**
Source: ICU Nurse Manager	Effective Date:

DOCUMENTATION:
Document how patient tolerated procedure, size of catheter used and flushing of catheter after each lab draw.

Reference: Med-Surg Nursing, page 23, February, 1993
Committee(s) approval needed: Nurse Management Group
Responsibility for review and maintenance: Med-Surg Nurse Manager; ICU Nurse Manager; Infection Control Practitioner
Index Listings: Blood Draw-Saline Lock; Saline Lock – Blood Draw;
IV Therapy: Blood Draw-Saline Lock; IV Therapy: Saline Lock-Blood Draw
Initiated: 3/93
Revised/Reviewed: 6/94; 7/96; 5/2000 BM; 02/2006 SM, 6/11jk ,9/12jk
Last Board of Director review: 4/18/18; 1/16/19; 6/19/19; 3/18/2020

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Scope of Service for the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: MNGR ED DISASTER PLANNING	Effective Date: 6/30/16

Purpose:

To offer emergency services to patients whose emergent medical needs can be met within the capabilities of the hospital staff and facilities

Department Description:

The Emergency Department (ED) is an 8-gurney department on the first floor of the hospital with separate ambulatory patient and ambulance entrances. The department has a triage room, a 2-bed trauma room and 6 other treatment rooms. One treatment room has been designed for OB/GYN. The unit has two patient bathrooms, one with a shower. There is also a decontamination shower with an entrance adjacent to the ambulance entrance. There is also a door leading into the main ED. Within the ED is a Radiology/Fluoroscopy room.

Mission:

Improving our communities one life at a time. One team. One Goal. Your Health.

Vision:

Northern Inyo Healthcare District will be known throughout the Eastern Sierra Region for providing high quality, comprehensive care in the most patient friendly way, both locally and in coordination with trusted regional partners.

Scope:

The ED provides basic emergency services for patients of all ages on a 24 hour a day basis. An ED physician will provide a medical screening exam on all patients, regardless of the ability to pay. The ED Unit serves as a Base Station for Inyo County ambulances and directs pre-hospital care via the Base Station radio following appropriate protocols

A dedicated triage nurse will triage all patients using the Emergency Severity Index (ESI) 5-level triage system. Following emergency assessment, diagnosis and treatment, patients may be admitted to the hospital, transferred to a tertiary care center or discharged home.

Patients transferring to a tertiary center are primarily transported by fixed wing or if appropriate by ground ambulance transport. Transfer agreements are in place.

Staffing:

The department is staffed with at least one physician experienced in emergency care twenty four hours a day, seven days a week.

Nursing staff includes:

Emergency Department Manager

Emergency Department Assistant Manager

RNs

Clerk/Technician

Care is delivered under the direction of the ED Physician on duty and/or private MD in attendance if properly credentialed.

The ED management is a joint function of the Medical Staff and Nursing Department and requires close

Title: Scope of Service for the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: MNGR ED DISASTER PLANNING	Effective Date: 6/30/16

cooperation with: ED Physicians, Attending Medical staff, Nursing units staff, Respiratory Therapy, Lab, Pharmacy, EKG, Dietary and Radiology departments, Information Technology, and Admission Services.

Ages Serviced:

The ED provides care across the life span
Neonate: birth -28 days
Pediatrics: 28 days to <13 years
Adult: 13 to 65 years
Geriatric: > 65 years

Quality Assurance/ Performance Improvement (QA/PI) :

The ED Manager and Assistant Manager with the assistance of the QAPI representatives, integrates all nursing quality assurance/improvement functions on the unit, tracks identified problems, assist the ED nursing unit in the development and evaluation of effective performance improvement reviews, ensures appropriate follow up occurs, and prepares reports concerning ED nursing performance improvement programs for the Nurse Management Performance Improvement Committee. Activities of the Emergency Department Performance Improvement program will be documented in the minutes of the unit staff meetings and will be reported to the QA/PI department quarterly.

Pillars of Excellence will be developed by:

1. Involving all nursing staff members in problem identification, determination of process system failures, development of solutions and in promoting quality patient care.
2. To periodically review and revise nursing indicators for the ED.
3. To analyze the information collected through ongoing monitoring of patient care provided by nursing staff, establish priorities in targeting areas of patient care for review
4. To identify problems or trends through analysis of the collected information.
5. To provide recommendations for actions to resolve identified problems.
6. To continue to follow up and review the results of action taken to determine if a problem has been resolved or if there is a need for further action.

REFERENCES:

Emergency Severity Index: A triage Tool for Emergency Department, Version 4

CROSS REFERENCES:

EMTALA Policy
Evaluation a d Medical Screening of Patients Presenting to the Emergency Department
Triage Protocol
Standards of Care in the Emergency Department

Approval	Date
NEC	2/21/18
ER Medical Services	3/14/18
MEC	4/3/18

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Scope of Service for the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: MNGR ED DISASTER PLANNING	Effective Date: 6/30/16

Board of Directors	4/18/18
Last Board of Director review	6/19/19

Developed:
Reviewed: 02/2018, 1/2018gr
Revised: 05/2016 as

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Sexual Assault Exam Policy**	
Scope: Emergency Dept	Manual: Emergency Department
Source: MNGR ED DISASTER PLANNING	Effective Date: 12/01/2014

PURPOSE:

To promote appropriate physical care and compassionate emotional care to victims of suspected sexual assault.

POLICY:

1. To provide a complete forensic examination with accurate documentation.
2. To provide the patient with the necessary follow-up options regarding data, medical, emotional and financial issues.

PROCEDURE ON PATIENT ARRIVAL:

1. Triage patient. **First respond to acute injury and trauma care needs.**
   - Forensic exam process can continue only after emergent and traumatic injuries have been evaluated and treated as necessary.
2. The victim will be provided with privacy immediately upon arrival and during all aspects of care.
3. Notify law enforcement if not already notified of patients arrival in the Emergency Department (ED).
   - If patient arrives with law enforcement, obtain a brief history from officer
   - If patient arrives by self, with family, friend, or rape crisis advocate, notify law enforcement.
   - Law enforcement should be notified regardless of whether the victim wants to report the assault or not.
4. Notify Wild Iris advocate of patient arrival if not already notified by law enforcement.
   - Wild iris advocate is valuable emotional support and can provide patient with information regarding victim services.
5. Obtain authorization from law enforcement for sexual assault (SA) evidentiary forensic exam.
6. Obtain consent from patient for SA forensic exam.
   - In CA. Age of consent for SA examination is 12 and above.
   - California Family Code Section 6928 statute requires the professional person providing medical treatment to a minor victim of sexual assault must attempt to contact the minor's parent unless the treating professional person reasonably believes the parent/guardian was the perpetrator. CHA recommends that the treating professional talk to the minor sexual assault victim about contacting the parent and then contact the parent unless the minor voices significant concern.
   - Document time and date of call from ED to parent/guardian and whether contact was successful or not. The basic message should be, "Your child is in the hospital."
   - Initial verbal consent from patient is acceptable to initiate SA process but written consent should be signed soon after.
7. **Forensic SA evidentiary examination can be done only if both law enforcement authorization and patient consent is given.**
8. SA forensic examination will be provided by ED registered nurse (RN) in order of availability.
   - Sexual Assault Forensic Examiner (SAFE) RN on duty.
   - ED RN with completed SA competencies and SA hospital training on duty.
   - Called in SAFE RN not on duty
   - Called in SA hospital trained, competent ED RN not on duty
9. Notify House Supervisor of SA patient's presence in ED and pending examination for staff coverage.
10. An ED chart is generated as normally done.

Title: **Sexual Assault Exam Policy**	
Scope: Emergency Dept	Manual: Emergency Department
Source: MNGR ED DISASTER PLANNING	Effective Date: 12/01/2014

- Clerk will provide labels for evidence collection.
- ED chart labels will not have patients Primary Medical doctor (PMD).

11. Have MD order lab tests through Paragon for urine early pregnancy test (EPT), HIV, Hepatitis C antibody.
    - Collect dirty urine specimen for pregnancy test. (no wiping before or after urine collection).
    - Draw blood for HIV and Hepatitis C antibody.
    - If initial interview reveals possible drug or alcohol involvement in assault, physician may order urine toxicology screen and serum blood alcohol level.
    - Law enforcement may request separate forensic blood tubes for evidence kit.

PROCEDURE FOR FORENSIC EXAM:

1. Make sure all consents are signed by law enforcement and patient before start of exam.
    - Cal-EMA 2-923 Form. (Victim- acute assault < 72 hrs.)
    - Authorization to Disclose Health Information- released to patient's preference.
1. Provide physical comfort.
    - If patient is cold, collect clothing as per evidentiary procedure and provide gown and blanket.
    - If thirsty, collect oral swabs before fluids are given.
2. Gather all necessary equipment for exam. Preferably in Rm. # 6.
    - SA Cart (in Supply Storage Room)- contains tape, scissors, markers, extra slides, cover slips, Envelopes, bindle paper, 10 ml saline, 10 ml sterile water, lab tubes, Speculums, anoscope, peri- pads, lab tubes
    - Victim Evidence Kit
    - Specimen Dryer- wipe dryer with 10 % bleach wipe prior to use and turn fan on to maximum hour.
    - Woods Lamp
    - Camera
    - Red Box with SA medications.
3. Proceed with evidentiary exam as per Cal- EMA protocol.
    - Examiner obtains assault history, perform physical examination and evidentiary collection according to protocol
    - ED Physician will perform pelvic and anal exam.
    - RN is responsible for labeling all evidence including vaginal/cervical/anal swabs collected by MD.
    - All evidence collected goes inside evidence kit. Forensic blood tubes, if collected, go in a separate box.
4. NEVER LEAVE THE EVIDENCE UNATTENDED. Have another staff member check in room occasionally if anything is needed.
5. Double check Cal-EMA form for completeness.
6. Make 2 copies of completed Cal-EMA exam forms.
    - 1 copy goes to law enforcement
    - 1 goes with ED chart
    - Original form goes inside evidence box before it is sealed.
7. Do not tear down ED chart.

Title: **Sexual Assault Exam Policy**	
Scope: Emergency Dept	Manual: Emergency Department
Source: MNGR ED DISASTER PLANNING	Effective Date: 12/01/2014

- Place Cal-EMA forms and ED chart in yellow envelope marked *Confidential* and deliver to Emergency Department Manager.
- During off- hours, request house supervisor to open Managers office and leave chart on desk.

TREATMENT and FOLLOW UP:

1. Offer patient hospital emergency contraception and sexually transmitted disease (STD) prophylaxis.
   - Verify results of EPT before giving meds.
   - Medications are in red box- in med room.
     - Ceftriaxone 125 mg intramuscular injection
     - Azithromycin 1 Gram by mouth
     - Metronidazole 2 Grams by mouth
     - Plan B 1 tablet by mouth
   - If .patient is allergic to any meds, there are other options available (call pharmacy)
   - If patient takes any of the meds, fill out charge sheet and send with ED chart and call pharmacy to refill box.
2. Inform patient they can choose to have the follow up with their primary physician or with Inyo County Health Dept.
   - If pt. chooses to follow up with Health Dept, follow up call will be in 5-7 days.
   - Contact Health Department SA RN and give information re: date of exam and patients name, meds given, labs drawn and brief patient medical history.
   - Further information can be obtained by Health Department from Medical Records
3. Follow up may include:
   - Test result disclosure
   - HIV/Hepatits C Counseling
   - Re-evaluation of physical injuries
   - Reevaluation for pregnancy and STD
   - Assessment for Rape Trauma Syndrome
   - Social services assistance
4. Discharge patient through Logicare with diagnosis of sexual assault and other medical diagnosis if present. Include teaching regarding any prophylactic medications given in ED.

5. Notify Director of Revenue Cycle of SA examination and give date, name of RN, and MD involved in exam. This is for charging purposes since SA chart does not follow the usual charging process.

DOCUMENTATION:

1. Documentation will be done as always in the ED chart. Triage complaint is entered as Sexual Assault and medication profile completed in Paragon.

Title: **Sexual Assault Exam Policy**	
Scope: Emergency Dept	Manual: Emergency Department
Source: MNGR ED DISASTER PLANNING	Effective Date: 12/01/2014

2. All information related to the forensic evidentiary examination are documented in the appropriate Cal-EMA form.

REFERENCES:

1. California SART Report (2009). California Clinical Forensic Medical Training Center. UC Davis Health System.
2. California Hospital Association Consent Manual 2016.Section 2, page 2.23

CROSS REFERENCES:

1. Suspicious Injury Reporting
2. Working with other Agencies in the Community
3. Intimate Partner Abuse Guidelines
4. Child Abuse or Suspected Abuse or Sexual Assault Guidelines

Approval	**Date**
Clinical Consistency Oversight Committee	5/21/18
Emergency Room Medical Committee	7/9/18
MEC	8/7/18
Board of Directors	8/15/18
Last Board of Director review	6/19/19

Developed: 12/2000
Reviewed: 2003, 2006, 2009, 2012, 2015as, 4/2018 gr
Revised: 12/2000; 2/2002, 2014as

NORTHERN INYO HEALTHCARE DISTRICT
POLICY AND PROCEDURE

Title: Standardized Procedures for Medical Functions in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: DIRECTOR OF NURSING ED AND INPATIENT SERVICE	Effective Date: 6/10/19

PURPOSE:
The purpose of the policy is to define designated medical functions that may be performed by the RN as a standardized procedure in the ED.

POLICY:
It is the policy of Northern Inyo Healthcare District (NIHD) that only standardized procedure functions based on defined circumstances as outlined in this document may be performed by a Registered Nurse (RN) in the Emergency Department (ED) without previous written authorization of the Emergency Department Physician or Licensed Independent Practitioner (LIP).

PROCEDURE:

1. Competency Requirements
    a. To be eligible to perform this standardized procedure in the ED, the RN must:
        i. Hold a current CA RN License
        ii. Complete an initial training course specific to the elements of the standardized procedure outlined in this policy.
        iii. Competency is demonstrated annually and documented in the employee's competency assessment files.
        iv. A list of RN's competent to perform this standardized procedure is maintained with the Chief Nursing Officer and is updated annually.
        v. Standardized procedures are reviewed and approved annually by the Interdisciplinary Practice Committee.
2. Abdominal Pain
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 18 years of age and older presenting with complaint of Abdominal Pain with a documented Emergency Severity Index (ESI) level 2-5.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Abdominal Pain and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
            1. Saline Lock
            2. NPO
            3. CBC with automated differential

4. Comprehensive Metabolic Panel
5. Urine Dip and Hold Urine
6. Urinalysis, culture and sensitivity if urine dip shows leukesterase or nitrates
7. Female 10 years of age to 60 years of age:
    a. Pregnancy Test Urine Qualitative
8. For Upper Abdominal Pain:
    a. Lipase
    b. EKG if age >35
9. If nausea present:
    a. Ondansetron (Zofran) 4 mg IV X1
10. If vomiting present:

    If no medical history of Chronic Renal disease or heart failure, Normal Saline Bolus 1000ml

d. Complications:
    i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.
e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

3. Chest Pain 35 years of age and older
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 35 years of age and older presenting with complaint of Chest Pain with a documented ESI level 2-5.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Chest Pain and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
            1. STAT EKG
            2. Continuous Pulse Oximetry
            3. Continuous Cardiac Monitoring
            4. Saline Lock
            5. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
            6. CBC with automated differential

7. Comprehensive Metabolic Panel
8. Troponin I
9. If patient takes Coumadin:
    a. Prothrombin Time (PT) and INR
    b. Partial Thromboplastin Time
10. Oxygen via nasal cannula to keep oxygen saturation >95%
11. Aspirin 325mg PO Stat if not taken prior to arrival, or equivalent to equal 325mg if partial dose taken prior to arrival, and no contraindications to aspirin

d. Complications:
    i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.
e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

4. Chest Pain 16 years of age to 34 years of age
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 16 years of age to 34 years of age presenting with complaint of Chest Pain with a documented ESI level 2-5.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Chest Pain and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
            1. STAT EKG
            2. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
    d. Complications:
        i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:
        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.
5. Dysuria
    a. Circumstances under which the procedure maybe performed:

i. Any patient presenting to the ED with complaint of Dysuria with a documented ESI level 2-5.

b. Circumstances under which the Physician or LIP must be contacted:
   i. Any patient classified as an ESI Level 1.
   ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
   iii. Any significant change in patient condition

c. Standardized procedure:
   i. Upon presentation to the ED with complaint of Dysuria and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
      1. Urine Dip and Hold Urine
      2. Urinalysis, culture and sensitivity if urine dip shows leukesterase or nitrates
      3. Female 10 years of age to 60 years of age:
         a. Pregnancy Test Urine Qualitative

d. Complications:
   i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
   i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

6. Fever 16 years of age and older
   a. Circumstances under which the procedure maybe performed:
      i. Any patient in the ED 16 years of age and older presenting with complaint of fever with a documented ESI level 2-5.
   b. Circumstances under which the Physician or LIP must be contacted:
      i. Any patient classified as an ESI Level 1.
      ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
      iii. Any significant change in patient condition
   c. Standardized procedure:
      i. Upon presentation to the ED with complaint of fever and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
         1. Acetaminophen 650mg PO X1 for temperature >100.5 Fahrenheit if unable to swallow may order PR.
         2. If Acetaminophen has been administered in the last 6 hours, and Ibuprofen has not been administered in last 6 hours, order will be placed for Ibuprofen 600mg PO X1.

d. Complications:
    i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.
e. Documentation:
    i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

7. Fever 3 months of age to 15 years of age
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 3 months to 15years of age presenting with complaint of fever with a documented ESI level 2-5.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of fever and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
            1. Acetaminophen Suspension 15mg/kg PO X1 (maximum dose 1000mg) for temperature >100.5 Fahrenheit if unable to swallow notify ED Physician or LIP. If patient is greater than 6 months of age and Acetaminophen has already been administered in last 6hours and Ibuprofen has not been administered in last 6 hours, order will be placed for Ibuprofen 10mg/kg PO X1 (maximum dose 600mg) for temperature greater than 100.5 Fahrenheit.
    d. Complications:
        i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:
        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.
8. Extremity Deformity or pain from trauma
    a. Circumstances under which the procedure maybe performed:
        i. Any patient in the ED 5 years of age and older presenting with extremity deformity or pain from trauma with a documented ESI level 2-5, and assessed to have normal circulation, movement, and sensation in the distal extremity.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.

ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
iii. Any significant change in patient condition

c. Standardized procedure:
   i. Upon presentation to the ED with extremity deformity or pain from trauma assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
      1. If Ibuprofen has not been administered in the last 6 hours order will be placed for Ibuprofen 10mg/kg max dose of 600mg PO X1, if no NSAIDS have been taken in the last 6 hours.
      2. Contact ED Physician or LIP for pain medication order if needed
      3. Obtain Radiology: X-ray of the affected extremity
      4. Ice Therapy
      5. Elevate affected extremity

d. Complications:
   i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:
   i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

9. Vomiting 18 years of age and older
   a. Circumstances under which the procedure maybe performed:
      i. Any patient in the ED 18 years of age and older presenting with complaint of vomiting with a documented ESI level 2-5.
   b. Circumstances under which the Physician or LIP must be contacted:
      i. Any patient classified as an ESI Level 1.
      ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
      iii. Any significant change in patient condition
   c. Standardized procedure:
      i. Upon presentation to the ED with complaint of vomiting and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
         1. Place Saline Lock
         2. If no medical history of Chronic Renal disease or heart failure, Normal Saline Bolus 1000ml
         3. Ondansetron (Zofran) 4mg IV X1
   d. Complications:

i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:

i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

10. Vomiting 6 months of age to 17 years of age

a. Circumstances under which the procedure maybe performed:

i. Any patient in the ED 6 months to 17 years of age presenting with complaint of vomiting with a documented ESI level 2-5.

b. Circumstances under which the Physician or LIP must be contacted:

i. Any patient classified as an ESI Level 1.
ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
iii. Any significant change in patient condition

c. Standardized procedure:

i. Upon presentation to the ED with complaint of vomiting and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.

1. Ondansetron (Zofran) 0.5mg/kg Oral Disintegrating Tab (ODT), max dose 4mg.

d. Complications:

i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:

i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

11. Shortness of Breath WITH history of Asthma

a. Circumstances under which the procedure maybe performed:

i. Any patient presenting to the ED with complaint of Shortness of Breath with history of Asthma and with a documented ESI level 2-5.

b. Circumstances under which the Physician or LIP must be contacted:

i. Any patient classified as an ESI Level 1.
ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
iii. Any significant change in patient condition

c. Standardized procedure:

i. Upon presentation to the ED with complaint of Shortness of Breath with history of Asthma and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
   1. Continuous pulse oximetry
   2. Oxygen administration titrate to keep saturation >90%
   3. Duoneb x1

d. Complications:
   i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:

   i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

12. Shortness of Breath 18 years of age and older without history of Asthma
   a. Circumstances under which the procedure maybe performed:
      i. Any patient presenting to the ED 18 years of age and older with complaint of Shortness of Breath without history of Asthma with a documented ESI level 2-5.
   b. Circumstances under which the Physician or LIP must be contacted:
      i. Any patient classified as an ESI Level 1.
      ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
      iii. Any significant change in patient condition
   c. Standardized procedure:
      i. Upon presentation to the ED with complaint of Shortness of Breath without history of Asthma and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
         1. Saline Lock
         2. Continuous pulse oximetry
         3. Continuous cardiac monitoring
         4. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
         5. EKG if patient >35 years of age
         6. Oxygen administration titrate to keep saturation >90%
         7. If wheezes are present:
            a. Duoneb x1
   d. Complications:

i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.

e. Documentation:

i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

13. Shortness of Breath 17 years of age and younger without history of Asthma
    a. Circumstances under which the procedure maybe performed:
        i. Any patient presenting to the ED 17 years of age and younger with complaint of Shortness of Breath without history of Asthma with a documented ESI level 2-5.
    b. Circumstances under which the Physician or LIP must be contacted:
        i. Any patient classified as an ESI Level 1.
        ii. Any patient classified as an ESI level 2 will require notification within 10 minutes.
        iii. Any significant change in patient condition
    c. Standardized procedure:
        i. Upon presentation to the ED with complaint of Shortness of Breath without history of Asthma and assigned an ESI level 2-5, if the physician or LIP cannot immediately evaluate the patient, the EDRN will place the following orders prior to the patient being seen by the ED Physician or LIP.
            1. Continuous pulse oximetry
            2. Chest X-ray 2 views, if able to stand. If unable to stand 1 view portable
            3. Oxygen administration titrate to keep saturation >90%
            4. If wheezes are present:
                a. Albuterol 2.5mg via hand held nebulizer x1
    d. Complications:
        i. Immediate Physician or LIP notification of abnormal Vital Signs and or change in status to higher priority category.
    e. Documentation:
        i. Patient specific information obtained for ED nursing documentation includes subjective data, objective data, and record of any actions taken per standardized procedure.

REFERENCES:

Title: Standardized Procedures for Medical Functions in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: DIRECTOR OF NURSING ED AND INPATIENT SERVICE	Effective Date: 6/10/19

1. **California State and Consumer Services Agency, Board of Registered Nursing. (2011). "*An explanation of the scope of RN practice including standardized procedures*". Retrieved from www.rn/gov Section 2725 of California Nurse Practice Act.**
2. **Emergency Severity Index (ESI) Implementation Handbook, 2012 Edition. Retrieved from www.ahrg.gov/researdh/esi/esi7.htm.**

Approval	**Date**
Emergency Services Committee	3/6/19
Pharmacy and Therapeutics Committee	2/21/19
Radiology Committee	2/19/19
Interdisciplinary Committee	2/13/19
MEC	4/2/19
Board of Directors	4/17/19
Last Board of Directors Review	4/17/19

Developed: 1/9/2019
Reviewed:
Revised:
Supersedes:
Index Listings:

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Thrombolytic Therapy Focus Review**	
Scope:	Department: **Emergency Dept, ICU/CCU**
Source: ED Nurse Manager	Effective Date:

Combined study with the ICU and the ER

MR # _____ Date _____ Type MI _____ Ambulance: ____ Yes ____ No

Was there a prolonged time from onset of symptoms to arrival at NIH? ____ Yes ____ No
If yes, reason: _____

Was the patient seen immediately on arrival? ____ Yes ____ No If no, why not? _____

EKG in house ___ On call ____ Response time _____ Done by the ED ____

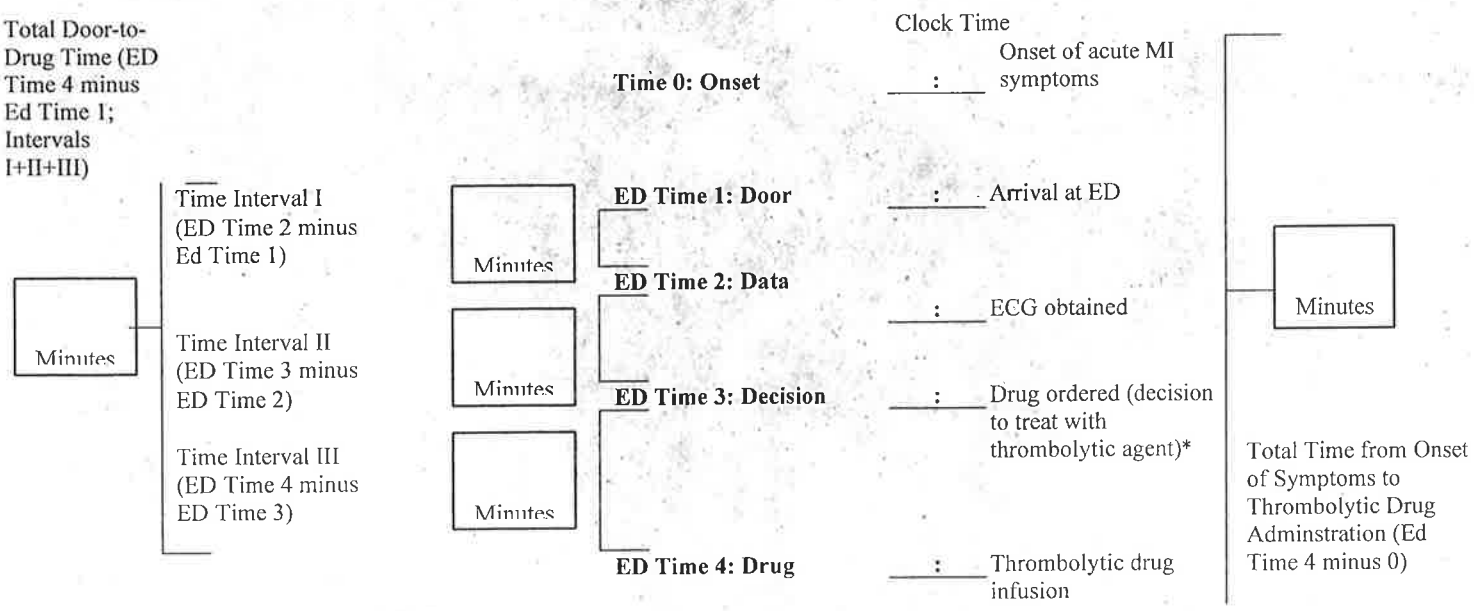
Name of Internist consulted _____
Data to decision time greater than 30 minutes ____ Yes ____ No If yes, secondary to: _____

EKG unclear ____ Yes No
Other complicating medical conditions ____ Yes ____ No If yes, what? _____

Waiting for Cardiology consult ____ Yes ____ No
Per Internist request ____ Yes ____ No
Other: _____

Pharmacist in house ____ Yes ____ On Call
Where you ready to start the drug before it was brought by pharmacy? ____ Yes ____ No
Could the drug have been started sooner with more available nursing staff? ____ Yes ____ No

Acute MI Time-to-Treatment Flowsheet



Last Board of Directors Review: 6/19/19

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: **Thrombolytic Therapy for Acute Myocardial Infarction**	
Scope:	Department: **Emergency Dept, ICU/CCU**
Source: MNGR ED DISASTER PLANNING	Effective Date: 6/16/04

PURPOSE:

Ensure the timely, safe and appropriate administration of thrombolytic therapy for the treatment of acute myocardial infarction (AMI)

POLICY:

1. Emergency Department (ED) physicians, Internal Medicine Physicians, Family Practice physicians trained in the management of AMI, may initiate thrombolytic therapy.

2. Tenectaplase (TNK) will be used exclusively for thrombolysis in AMI.

3. A Tenectaplase supply shall be available in the Emergency Department at all times. A back-up supply shall be available in the pharmacy.

4. A thrombolytic administration packet consisting of
    a. Acute MI Thrombolytic Therapy – Tenectaplase Order Sheet
    b. Patient Selection Worksheet For Thrombolytic Therapy
    c. Consent For Use Of Thrombolytic Therapy
    d. Frequent Vital Signs Sheet
    e. Drug Use Evaluation – Tenectaplase
    f. Nursing Focus Review
    - Packet contents are on the intranet: Forms>Departmental Forms>ED>MI TNK Packet http://intranet/Forms/Downtime/ED/Thrombolytic%20use%20Guidelines%20for%20Acute%20Myocardial%20Infarction.pdf

5. Nursing personnel shall provide the thrombolytic administration paperwork/packet (in the intranet) to the physician.

6. The Acute MI Thrombolytic Therapy – Tenectaplase order sheet shall be used to order TNK. TNK may also be ordered separately in CPOE.

7. The Emergency Department Physician may contact a cardiologist for consultation while giving thrombolytics and should also discuss coordination of further care of patient who has received thrombolytic therapy with transfer center physician.

8. The Emergency Department triage nurse will initiate the chest pain triage protocol upon determining that a patient has presented with chest pain:

    g. Oxygen therapy at an initial rate of 2 liters/min.
    h. Continuous cardiac monitoring, pulse oximetey and blood pressure monitoring,
    i. Chest X-Ray
    j. CBC, PT, PTT, Troponin, Chem-14, Type and Screen, UA

Title: **Thrombolytic Therapy for Acute Myocardial Infarction**	
Scope:	Department: **Emergency Dept, ICU/CCU**
Source: MNGR ED DISASTER PLANNING	Effective Date: 6/16/04

k. EKG
l. Aspirin 325mg if the patient has not taken aspirin or been given aspirin prior to arrival, and if the patient is not allergic to aspirin or related NSAIDs (e.g.: Ibuprofen, Naproxen).
m. Start an IV with Normal Saline 1000ml at 20ml/hr.

9. Start a 2nd IV if AMI is determined and TNK is to be administered. Verify with physician before breaking TNK seal.

10. Have patient sign consent prior to administration of TNK.

o 11. House supervisor shall be notified regarding patient transfer.

12. Nursing Focus Review and Drug Use Evaluation sheet shall be turned in to ED Manager after form is completed.

REFERENCE:

1. Genentech. TNkase (Tenectaplase). Retrieved from: https://www.gene.com/download/pdf/tnkase_prescribing.

CROSS REFERENCE:

1. Emergency Department Triage Protocols
2. Thrombolytic Therapy Consent

Committee Approval	**Date**
Clinical Consistency Oversight Committee	3/26/18
Emergency Services Committee	5/16/18
Med/ICU Committee	4/27/18
Medical Executive Committee	7/9/18
Board of Directors	2/20/19
Last Board of Director review	6/19/19

Revised 03/18 gr
Reviewed 6/11as; 2/15as, ; 1/17 LA

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Transfer of Evidence	
Scope:	Manual: Emergency Dept, Surgery
Source: Surgery Nurse Manager	Effective Date:

PURPOSE:
To assure all foreign objects that are could be classified as evidence are properly disposed of.

POLICY:
When disposing of evidence the following procedure will be adhered to:
BULLETS, KNIVES OR ANY FOREIGN OBJECT THAT WAS INTENDED TO DO BODILY HARM IN AN ASSAULT CASE COULD BE CLASSIFED AS EVIDENCE.

SPECIAL CONSIDERATIONS:
Physician order not required
Procedure may be performed by _X_RN ___LVN ___ OR Tech
Special education required to perform procedure: _X_No ___Yes

PROCEDURE:
1. If requested by a law enforcement officer, bullets or other specimens that may be regarded as evidence will be given directly in the chain of custody to Law Enforcement representatives.
2. The specimen should be placed in a specimen container by the physician or nurse. This container will be sealed and labeled by the nurse with the patient's name and identification number and then transferred directly to the investigating officer's custody. The investigating officer will sign the **"Disposition of Evidence"**: form and a copy of this will be included in the patient's medical record.
3. Specimens removed as evidence will not be sent to Pathology, but will be recorded separately as Non-Tissue Surgery which will be reviewed by the Surgery Tissue Committee monthly.
4. The specimen should be cleaned and terminally disinfected if this is approved by the investigating officer prior to its removal from the operating room environment, in order to comply with universal precautions.
5. If the item cannot be sterilized to terminally disinfect it, it should be disinfected utilizing a chemical disinfectant (cidex).

DOCUMENTATION:
The investigating officer's name, time, specimen and the name of the nurse or physician who transferred the specimen to the custody of the officer will be documented on the operating room record.

COMMITTEE APPROVAL: Not needed
Responsibility for Review and Maintenance: Surgery Nurse Manager
Index Listings: Transfer of Evidence; Disposition of Evidence; Bullets

Revised: 09/92 BS
Reviewed: 11/97; 8/2011BS
Last Board of Director review: 1/17/18; 1/16/19; 6/19/19, 3/18/2020

DISPOSITION OF EVIDENCE

Victim's Name _____

Date: _____ Time: _____

Hospital: _____

Attending Physician _____

Nurse _____

Description / Information _____

_____

_____

Chain of Custody

Evidence Delivered to: _____

Signature: Date/Time

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Trauma Patient Care in the Emergency Department	
Scope: Emergency Department	Manual: Emergency Dept
Source: Emergency Dept Nurse Manager	Effective Date: 03/2004

PURPOSE: Guideline for the care of the trauma patient in the Emergency Department (ED)

MAJOR TRAUMA CRITERIA:

1. Physiologic Indicators
   a. Glasgow Coma Scale (GCS)
      - At or less than 13 (Adult & Pediatric)
   b. Respiratory Rate
      - Less than 10 or greater than 29 (Adult and Pediatric)
      - Less than 20 (infants less than a year old) or need for ventilator support
   c. Hypotension
      - Adult
        - Less than 90 mmHg
        - Tachycardia
      - Pediatric
        - Exhibits inadequate tissue perfusion
        - Abnormal vital signs according to age
2. Anatomic Indicators:
   a. Penetrating injuries to head, neck, torso and extremities proximal to the knee or elbow
   b. Blunt chest trauma resulting in chest wall instability or deformity (e.g. 3 or more broken ribs)
   c. Two or more proximal long bone fractures (femur, humerus)
   d. Crushed, degloved, mangled or pulseless extremity
   e. Amputation proximal to wrist and ankle
   f. Unstable Pelvic fractures
   g. Paralysis

3. Mechanism of injury
   a. Falls
      - Adults: greater than 20 feet (one story = 10 feet)
      - Pediatric: greater than 10 feet or 2-3x the child's height
   b. High risk auto crash
      - Intrusion, including roof greater than 12 inches on occupants site
      - Ejection (partial or complete) from vehicle
      - Death in the same passenger compartment
      - Vehicle telemetry data consistent with high risk injury
      - Auto vs. pedestrian thrown, run over, or with significant impact (> 20 mph)
      - Motorcycle crash with greater than 20 mph speed

POLICY:

1. All patients will be triaged according to the Emergency Severity Index 5-level triage system.
   a. Care will be determined by the severity of their injuries, mechanism of injury and first

responder report.

2. The Emergency Nurse Association's Trauma Nurse Core Course (TNCC)"A through I Algorithm" will serve as a guideline for trauma assessment.
   a. Primary Survey
      - A- Airway
      - B- Breathing
      - C- Circulation
      - D-Disability
      - E- Exposure/Environment

   b. Secondary Survey
      - F- Full set of Vitals/ Family
      - G- Give Comfort Measures
      - H- Head to Toe Exam
      - I- Inspect Posterior Surface

3. Trauma team will consist of:
   a. Emergency Department Physician
   b. Trauma 1 RN (TN 1)
      - Coordinates / treatment plan with physician
      - Provides direct patient care
      - Responsible for documentation of primary and secondary surveys and re-evaluations
      - Places monitoring devices such as cardiac monitor, pulse oximeter and blood pressure cuff
      - Assist with airway management
      - Ensures that 2 large bore IV's are in place
      - Administers medications
      - May delegate other duties to other team members.

   c. Trauma 2 RN (TN 2)
      - Assist Trauma 1 RN with above duties
      - Insert NG/ OG tube, foley catheter
      - Set up and assist Physician with chest tube insertion, needle decompression, central line placement, arterial line placement.
      - TN 1 and TN 2 may change or delegate roles as necessary according to individual skills except for assessments and re-evaluations.

   d. Trauma 3 RN (if available or if needed) (TN3)
      - Undresses patient as able
      - General runner/helper
      - Provide CPR if necessary

   e. Trauma 4 RN
      - Record all information on trauma sheet
      - Obtains signatures from team members

- Reviews with TN 1 assessments and treatments/interventions

f. ED Tech/Clerk

- Call ancillary department staff as needed.
- Run monitor strips in central monitor as indicated
- Push CPOE orders as needed

4. ED Trauma CPOE orders may be used as directed by Physician.
5. Consultations with on-call physicians or transferring facility physicians are the responsibility of the ED physician.
6. The House Supervisor will then initiate contact with an air transport company as well as the bed control person at the accepting facility. This should be done as soon as possible to avoid delays.

For Major Trauma Victims:

1. Have portable ultrasound ready at bedside.
2. Notify Lab and Radiology of patient arrival.
3. Notify House Supervisor immediately of patient arrival and need for flight crew. This should be considered as soon as the MICN receives the radio report triaging the patient as a major trauma patient.
4. Lab should be notified to deliver four units of uncross-matched O-negative blood. Have Hotline warmer ready at bedside.
5.

REFERENCE:

1. Emergency Severity Index (ESI) A Triage Tool for Emergency Department Care Version 4, 2012 Edition
2. Emergency Nurses Association, Trauma Nurse Core Course 2012
3. EMTALA: A Guide to Patient Anti-dumping Laws 2009
4. Trauma Triage Criteria: ICEMA Policy and Procedures Protocol Manual, Reference 15030

CROSS- REFERENCE:

1. EMTALA Policy
2. Triage Policy
3. Evaluation and Medical Screening of Patients Presenting to the Emergency Department
4. Standards of Care in the Emergency Department

Committee (s) Approval:	**Date:**
CCOC	1/29/18
Emergency Services Committee	5/16/18
Medical Executive Committee	6/5/18
Board of Directors	6/20/18
Last Board of Director's Review	6/19/19

Revised: 1/2005, 09/07 AS, 08/11 AS 01/2018gr

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Warming Cabinet for Blankets/Solutions	
Scope:	Manual: Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Surgery
Source: Surgery Nurse Manager	Effective Date:

PURPOSE:

To ensure a safe method of warming textiles/fluids for patient use.
Warming cabinets are designed to raise the temperature of irrigation, IV solutions and or textiles (blankets) for patient use.
This is achieved by circulating air warmed by heaters throughout the heating compartment.

POLICY:

When warming textiles and or fluids for patient use this policy will be utilized.

SPECIAL CONSIDERATIONS:

Physician Order required: _X_ No, ___ Yes
Procedure may be performed by: _X_ RN, _X_ LVN, _X_ Tech, _X_ Clerk
Special education required to perform procedure: _X_ No, ___ Yes
Review this policy/procedure and monitor temperature to prevent patient injury.
Age specific considerations: None

EQUIPMENT:

Warming cabinet, textiles/fluids to be warmed.

PRECAUTIONS:

Assure temperature is appropriate for solutions/textiles.
Allow room for airflow when stocking with textiles/solutions.
Solutions must not come in contact with metal in the warming units.
Solutions must not come in contact with heating elements.
Mannitol solutions may not be stored in the warmer.

PROCEDURE:

a. If utilizing unit for both textiles and fluids, place solutions and textiles on shelves as indicated in operators manual for specific unit. They should be on separate shelves.
b. To ensure proper heat distribution, allow airflow space on the top and all sides of textiles. DO NOT BLOCK AIR VENT.
c. Blankets must be folded and stacked to allow a 2" to 3" open space between the blankets and the interior walls and door to allow for even heat distribution and proper cabinet operation.
d. TEXTILES (Blankets) can be warmed to a temperature 130 DEGREES PLUS OR MINUS 5 DEGREES. Always feel the blanket to assure it is not too warm for patient use prior to placing on patient.
   Rotate textiles when stocking cabinet.
e. After setting temperature per manufacture recommendation, the alarm will alert you if the temperature exceeds the temperature control setting plus 10 degrees F.
f. Solutions are warmed per manufacture recommendations. We utilize Abbott Laboratories solutions and the following guidelines are specific for these products.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Warming Cabinet for Blankets/Solutions	
Scope:	Manual: Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Surgery
Source: Surgery Nurse Manager	Effective Date:

SOLUTIONS FOR INJECTIONS

a. Solutions should remain in their overwraps and can remain in the warmer for a period NOT LONGER THAN 14 DAYS AT 104 DEGREES F.
b. Solutions should not come in contact with metal components within the warming unit.
c. Once removed from the warming unit, solutions should be used within 24 hours or discarded and not returned to stock supply.
d. Solutions should not be rewarmed.
e. Solutions should be dated with REMOVAL DATE when placed in warming unit and the temperature checked daily.

IRRIGATION SOLUTIONS

a. Flexible Irrigation solutions (bags) should remain in their overwraps and can remain in the warmer for a period of NOT LONGER THAN 14 DAYS. Flexible irrigation containers can be warmed up to a temperature of 150 degrees F according to Solution Manufacture Recommendation.
b. Semi- rigid pour bottles may remain in the warming cabinet for up to 60 days at a temperature up to 150 degrees F according to Solution Manufacture Recommendation.
c. To ease cap removal for the pour bottles it is recommended that you wait for four minutes after removal of the product from the warming cabinet.
d. IF YOU HAVE BOTH FLEXIBLE IRRIGATION SOLUTIONS AND RIGID POUR BOTTLE IRRIGATIONS, THEN YOU MUST USE THE LOWER TEMPERATURE WHENWARMING THE SOLUTIONS WHICH IS 104 DEGREES F.
e. When placing solutions in the warmer, the solutions should be dated with DATE PLACED INTO WARMER AND DATE OF EXPIRATION. Preprinted labels are available and should be used. Writing with a pen on the bag should not be done.
f. A temperature log will be kept on the warming cabinet and the temperature will be logged daily.

LOADING TECHNIQUES:
All temperatures of solutions and Textiles (blankets) should be allowed to stabilize at the set temperatures.

SOLUTIONS:	In Bottles	Approximately 8 hrs.
	In Bags	Approximately 12 hours
BLANKETS:		Approximately 8 hours

If it is necessary to remove only part of a load from the cabinet, then a FIFO (First in First Out) routine is recommended.

DOCUMENTATION:

Each Nursing Unit will complete the temperature checklist on a daily basis documenting the date, time, and initials of person checking the unit.

NORTHERN INYO HOSPITAL
POLICY AND PROCEDURE

Title: Warming Cabinet for Blankets/Solutions	
Scope:	Manual: Emergency Dept, ICU/CCU, Medical/Surgical, PACU, Surgery
Source: Surgery Nurse Manager	Effective Date:

Committee approval needed: __No, _x__Yes Pharmacy Committee Meeting 2/01
Nurse Management 3/01

Responsibility for Review and Maintenance: Perioperative Nurse Manager
Index Listing: Warming Cabinet for Blankets/Solutions
INITIATED: 2/01; 5/11 BS
Last Board of Director review: 1/17/18; 1/16/19; 6/19/19, 3/18/2020